Health risks, alcohol, and tobacco in Britain and West Germany, 1948-1990.

This dissertation is submitted for the degree of Master of Philosophy. This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except where specifically indicated in the text.

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List of Abbreviations

AfJ	Information Service for Youth Protection (*Aufklärungsdienst für Jugendschutz*)
ASH	Action on Smoking and Health
BAC	Blood Alcohol Content
BMA	British Medical Association
BMG	Federal Ministry of Health (*Bundesministerium für Gesundheitswesen*)
BMJFG	Federal Ministry for Youth, Family, and Health (*Bundesministerium für Jugend, Familie, und Gesundheit*)
BZgA	Federal Centre for Health Education (*Bundeszentrale für gesundheitliche Aufklärung*)
CCHE	Central Council for Health Education
CDU	Christian Democratic Union (*Christlich Demokratische Union*)
DGM	German Health Museum (*Deutsches Gesundheits-Museum*)
DHS	German Agency against the Dangers of Addiction (*Deutsche Hauptstelle gegen Suchtgefahren*)
DHSS	Department of Health and Social Services
EEC	European Economic Community
HEC	Health Education Council
ISCSH	Independent Scientific Committee on Smoking and Health
MRC	Medical Research Council
NHS	National Health Service (of England and Wales)
NSM	New Smoking Material
RCP	Royal College of Physicians
SPD	Social Democratic Party of Germany (*Sozialdemokratische Partei Deutschlands)*
WHO	World Health Organisation
VdC	Association of the Cigarette Industry (*Verband der Cigarettenindustrie*)

Introduction

During the second half of the twentieth century, state attitudes to tobacco consumption in Britain have been transformed, from endorsement of cigarette smoking during the World Wars to increasing regulation of import and sale, and dis-incentivisation of consumption. In the same period, restrictions on alcohol licensing and public health warnings about consumption have proliferated, transforming perceived-as-excessive consumption from a moral deviation to irresponsible health behaviour. Despite what has been depicted as a more liberal approach, other European nations like Germany have also sought, directly or indirectly, to regulate consumption habits in the name of preventive health, not confined to but exemplified by alcohol and tobacco; goods described in Germany as *Genussmittel* – things consumed for pleasure or stimulation, rather than nutrition. These new forms of preventive regulation emerged as part of what historians, theorists, and practitioners of public health have identified as a 'new approach' to public health emerging in the second half of the twentieth century, based on the identification of disease risk factors at a population level, and individual responsibility for lifestyle modification.[1] Knowledge about health risks has become central to health promotion, but the identification of health risks is not a value-free process. Medical scientific knowledge is neither objective nor static; objects of study, the interpretation of findings, and the transformation of findings into public knowledge are all defined by prevailing cultural and political frameworks.[2] These frameworks shape ways of thinking about new health risks – as individual or environmental, personal or social – and possible policy responses. This dissertation compares policy-makers' definitions of health risks associated with alcohol and tobacco, and the framing of policy responses, in Britain and West Germany between 1948 and 1990. It considers how these discourses reflect different, and changing, political structures and ideologies, and asks what they can tell us about the experiences of different kinds of welfare states during the period in which neoliberalism began to thrive.

The 'watershed' work revealing a statistical correlation between tobacco smoking and lung cancer was published by Richard Doll and Austin Bradford Hill in Britain in 1950, but it was not until the 1970s that warning labels, national primary education programs, and punitive taxation were used as tools to combat smoking. Much of the literature on responses to tobacco

[1] Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain* (Oxford: Oxford University Press, 2007), pp. 17-8; Rob Baggott, *Public Health: Policy and politics* (Basingstoke: Macmillan, 2000), p. 51; Geoffrey Rose, *The Strategy of Preventive Medicine* (Oxford: Oxford UP, 1992), p. 106.
[2] Theodore M. Porter, *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life* (Princeton: Princeton University Press, 1995), p. 90.

health risks has emphasised government relationships with the tobacco industry as an explanatory factor for what has been described as 'denial and delay' in tobacco regulation from the 1950s to 1970s.[3] Allen Brandt's influential study, based upon scrupulous source work in the American context, generalises a tale of corporate iniquity to a global setting, describing the 'massive pandemic' represented by 'the global harms of smoking'.[4] Subsequent sensationalist accounts have captivated readers and federal judges alike, but those offered by authors involved in anti-smoking and anti-industry activism are problematic if not parochial.[5] Virginia Berridge has refuted Whiggish histories of substance regulation as a story of the progress of medical knowledge in the face of corporate denial, and emphasised the interaction between prevailing public health ideologies and wider economic and social factors in establishing policy knowledge in Britain.[6] Similarly, in the area of alcohol, John Greenaway has shown that the timing of policy-maker's increasing 'anxiety' about alcoholism from the late-1960s reflected concern about rising levels of consumption, rather than a sudden awareness of scientific concepts formed in the previous decade.[7] James Nicholls has argued that attitudes toward alcoholism and drunkenness, as well as broader ideas about rationality, responsibility, and pleasure, affected the interpretation of new scientific knowledge, by both policy-makers and polity.[8]

This dissertation contributes to this literature enlightening the national specificities of the relationship between scientific and policy knowledge, by conducting a comparative study of Britain and West Germany. Tobacco and alcohol are taken together, as while the statistical correlation between smoking and lung cancer produced a new and increasingly unequivocal health risk during the second half of the twentieth century, drink provides a 'cultural constant'; a good whose consumption has long been vaguely associated with moral vice, but whose ubiquitous presence throughout history allows us to reflect on changing social and political values as they impact the perceived risks of consumption.[9] The dissertation brings together the

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[3] David Pollock, *Denial & Delay: The Political History of Smoking and Health 1951-1964, Scientists, Government and Industry as seen in the papers at the Public Records Office* (London: ASH, 1999).
[4] Allen M. Brandt, *The Cigarette Century: The Rise, Fall and Deadly Persistence of the Product that Defined America* (New York: Basic Books, 2007), pp. 14-15.
[5] Robert N. Proctor, *Golden Holocaust; Origins of the Cigarette Catastrophe and the Case for Abolition* (London: University of California Press, 2011), for example, was published after Proctor had appeared as an expert witness in 45 separate lawsuits against tobacco companies; prior to testifying in forty further cases since.
[6] Berridge, *Marketing Health*, p. 5*;* Virginia Berridge, *Demons: Our changing attitudes to alcohol, tobacco, and drugs* (Oxford: Oxford University press, 2013), pp. 3, 12.
[7] John Greenaway, *Drink and British Politics since 1830* (New York: Palgrave Macmillan, 2003), p. 161.
[8] James Nicholls, *The Politics of Alcohol: A history of the drink question in England* (Manchester and New York: Manchester University Press, 2009), pp. 2-3.
[9] Nicholls, *The Politics of Alcohol*, p. 257.

fruitful secondary literature on Britain, and sparser English-language work on West Germany, in order to draw out the different processes which 'push policy makers toward or away from particular public health policies or shape their implementation'; best achieved, attests Constance Nathanson, through international comparison.[10]

While the comparison between Britain and West Germany reveals nationally-specific processes which shape policy-makers' definitions of health risks and policy responses, the dissertation also describes a common transformation, identified by theorists of the 'new public health', toward the promotion of healthy behaviours by governments, based on a discourse of personal empowerment and individual management of scientifically-identified risk factors.[11] This contradiction, of increasing state intervention reliant on a discourse of personal freedom and responsibility, has not been directly addressed in the literature on alcohol and tobacco, with the exception of Mariana Valverde's *Diseases of the Will*, which presents a longer view of conceptions of alcohol-related disease since the seventeenth century, and is primarily concerned with North America, although with some reference to nineteenth- and twentieth-century Britain.[12] Robin Bunton has usefully described how community-based preventive responses to alcoholism since the 1970s have extended 'social mechanisms of control' over 'docile' citizens, but does not develop the framing of these forms of intervention as actually enhancing of freedom (not only efficiency).[13]

To this author's mind, the contradiction of intervention packaged as freedom is central to a discussion of tobacco and alcohol policy in the second half of the twentieth century, in the context of the proliferation of neoliberal ideas. Foucauldian theorists have depicted this paradox as a manifestation of 'neoliberal governmentality', wherein expert knowledge acts as a form of regulatory power which defines the terms of individual freedom.[14] Foucault describes this form of governmentality, or regulation of individual behaviour, as 'biopower'; the control over individual bodies in the name of public or social goals. That control is exercised through the indirect means of expert knowledge used to legitimise 'rational' behaviour, is described as a

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[10] Constance A. Nathanson, *Disease Prevention as Social Change: the state, society, and public health in the United States, France, Great Britain, and Canada* (New York: Russell Sage, 2007), p. 9.
[11] Alan Peterson and Deborah Lupton, *The New Public Health: Health and Self in the Age of Risk* (London: Sage, 1997), pp. 152-3.
[12] Mariana Valverde, *Diseases of the Will: Alcohol and the Dilemmas of Freedom* (Cambridge: Cambridge University Press, 1998), pp. 53-8; 156-71.
[13] Robin Bunton, 'Regulating our favourite drug', ch. 7 in Pamela Abbot and Geoff Payne (eds.), *New Directions in the Sociology of Health* (London: Falmer, 1990), p. 109.
[14] Nikolas Rose, 'Governing "advanced" liberal democracies', ch. 2 in Andrew Barry, Thomas Osbourne, and Nikolas Rose (eds.), *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government* (London: UCL Press, 1996), pp. 54-5.

feature of the neoliberal state.[15] While recent histories of alcohol and tobacco regulation have situated the shift toward personal responsibility for risk-averse behaviour within the context of discourses of individualism, some making direct reference to the Foucaldian perspective on neoliberalism,[16] the existing literature has not to this author's knowledge addressed the real-world discord between neoliberal ideas and neoliberal policy, central to the contradiction by which the concept of a 'neoliberal governmentality' is defined.

Berridge has argued that the concept of neoliberal governmentality does not accord with the history of alcohol regulation in Britain, as drinking is conceived of as both rational *and* irrational.[17] Berridge's objection to the Foucaldian explanation seems to respond to the use of 'neoliberal governmentality' as a static metaphor, failing to capture the development of contradictory justifications for policy in practice. Conceptions of risky behaviour as symptoms of a diseased or dependent (irrational) mind may seem inconsistent with neoliberal theories of individual rationality, but neoliberal policy practices are frequently contradictory. Foucaudian theorists recognise that while neoliberal ideas espouse the rationality of free individual decision-making under conditions of perfect information, even the state which does not intervene to co-ordinate market exchange plays a role in constructing the ways that individuals conceive of themselves – as rational, as self-actualising – and therefore the ways in which they behave.[18] However, because the concept of neoliberal governmentality defines neoliberalism in terms of this contradiction, it describes a static form of dissonance, where neoliberal subjects are governed by their perceived freedom, constituted by the state. This image of governance in an 'advanced liberal' moment fails to capture the development of neoliberal modes of regulation in practice. Foucault appreciates the historical development of biopower, describing nineteenth- and early-twentieth-century social medicine as an extension of state control through regulation of the 'things' that affect individual health, contrasted with indirect regulation of the individual body.[19] Neoliberal biopower is therefore conceptualised as historically contingent, but the concept of 'neoliberal governmentality' is defined by the *static* contradiction of the regulation of individuals constructed as individual freedom. The idea of 'neoliberal governmentality' is insightful, but the discord between neoliberal ideas (the idea of individual

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[15] Michel Foucault, *The Birth of Biopolitics: Lectures at the Collége de France 1978-1979*, trans. Graham Burchell (Basingstoke: Palgrave, 2008), pp. 92-3, 137-46.
[16] Nicholls, *The Politics of Alcohol*, p. 170; Rosemary Elliot, 'Inhaling Democracy: Cigarette Advertising and Health Education in Post-war West Germany, 1950s–1975', *Social History of Medicine*, advance access (15 March, 2015), pp. 5, 13.
[17] Berridge, *Demons*, p. 69.
[18] Rose, 'Governing "advanced" liberal democracies', p. 41.
[19] Michel Foucault, 'The Birth of Social Medicine', in Paul Rabinow and Nikolas Rose (eds.), *The Essential Foucault* (New York: The New Press, 2003), p. 332.

freedom) and neoliberal practice (the reality of regulation) is *dynamic*. The forms of regulation and government intervention which compose neoliberal practice are informed by neoliberal ideas, but forged in contexts shaped by pre-existing political structures and ideologies which differ from place to place.

The variety of neoliberal practice is not recognised in the literature on tobacco and alcohol regulation that draws upon Foucauldian theory, as the contradiction between neoliberal ideas and practice is not explicitly identified. The problem with failing to identify this variety is that local and national histories have the tendency to become so coloured by a single interpretation of ideological change that the specificities of policy knowledge and negotiation in a particular context are lost. A global history of policy is meaningless in a world which remains organised and governed by a system of nation states. This dissertation therefore seeks to identify the national differences in the political structures and ideologies that shape policy-makers' conceptions of health risks and policy responses, in Britain and West Germany, as well as the common features of '*neoliberalisation'* over time. Beyond using the concept of neoliberal governance as a metaphor for describing the discursive shift toward individual responsibility for risk-aversion, the dissertation charts the transformation toward neoliberal modes of governance through the lens of alcohol and tobacco policy-making.

The term 'neoliberalisation' is drawn from an alternative theory developed in human geography and political economy, of 'actually existing neoliberalism', which better captures the dynamic contradiction between neoliberal ideas and policy. Scholars of 'actually existing neoliberalism' define the *process* of neoliberalisation as a re-purposing of the state and its existing 'regulatory landscape' toward more market-oriented ends, through the regulation of perceived-as-free markets.[20] A number of scholars have observed that in the 'neoliberal era', since about 1975, despite a great deal of lip-service to the scaling back of welfare provisions and government intervention in private life, services have not usually been directly privatised, but rather sub-contracted, de-centralised, or de-regulated and re-regulated so that state responsibilities have been transformed.[21] That actually existing neoliberalism is in conflict with neoliberal *ideas* reflects the fact that neoliberal *practices* have been subject to 'political shape-shifting';

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[20] Neil Brenner and Nik Theodore, 'Cities and geographies of "Actually Existing Neoliberalism"', *Antipode*, 34:3 (2002), pp. 351-3.
[21] Joseph Stiglitz, *Economics of the Public Sector*, 3rd edition (New York: W.W. Norton, 2000), pp. 11-2; Steven K. Vogel, *Freer Markets, More Rules: Regulatory Reform in Advanced Capitalist Countries*, (Ithaca: Cornell University Press, 1996); Tim Anderson, 'The meaning of deregulation', *Journal of Australian Political Economy* 44:2 (1999), pp. 5-21.

moulded according to pre-existing ideologies, and adapted to particular needs.[22] Applying the insights of 'actually existing neoliberalism' to alcohol and tobacco policy-making, this dissertation identifies a discord between the policy practices that emerge in the process of neoliberalisation, and the neoliberal ideas which underpin them; ideas which prioritise individual decision-making on the basis that individual, preference-driven action is the optimal organising mechanism of society.[23] The individualisation of responsibility for health risk management has been effected through *increased* regulation – of a different character. The comparison between Britain and West Germany shows that, despite both being influenced by international ideas about the role of the individual in preventive health, and global networks of scientific knowledge identifying new health risks associated with alcohol and tobacco, policy-maker's definitions of health risks and policy responses to them reflect different, pre-existing political structures and ideologies.

Comparing political structures and ideologies

The comparison Britain and West Germany reflects the author's interest in building on existing secondary literature on these nations, but also the utility of the study as an empirical comparison of changing political structures and ideologies in two countries which have been depicted as different varieties of welfare state. European welfare states emerged from capitalist development and competition between states from the late-nineteenth century, but became the primary means of collectivising risk and social consciousness at the level of the nation after the Second World War.[24] These dual roles of the welfare state in the second half of the twentieth century represent its conflicting ideological bases, in *security* and *equality*.[25] While the pursuit of common security is based on collective alliances which promote formal equality, the heterogeneous coalitions necessary for the effective distribution of risk tend to impede mutualism and solidarity.[26] Welfare state structures which collectivise risk are constantly challenged and shaped by this tension, acting, according to Ulrich Beck, to break down traditional apparatus of social reproduction such as the church and family, and constitute instead

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[22] Jamie Peck, Nik Theodore, and Neil Brenner, 'Neoliberalism, interrupted', in Damien Cahill, Lindy Edwards and Frank Stilwell (eds.), *Neoliberalism: Beyond the Free Market* (Cheltenham: Edward Elgar, 2012), pp. 22-3.
[23] Christian Arnsperger and Yanis Varoufakis, 'What Is Neoclassical Economics? The three axioms responsible for its theoretical oeuvre, practical irrelevance and, thus, discursive power', *Panoeconomicus* 53:1 (2006), p. 13.
[24] Abram de Swaan, *In Care of the State: Health Care, Education and Welfare in Europe and the USA in the Modern Era* (Cambridge: Polity, 1988), pp. 224, 250-3.
[25] Peter Flora and A.J. Heidenheimer, 'Introduction', in their (ed. vol.), *The Development of Welfare States in Europe and America* (New Brunswick and London: Transaction, 1995), pp. 23-5.
[26] Peter Baldwin, *The Politics of Social Solidarity: Class Bases of the European Welfare State, 1875-1975*, (Cambridge: Cambridge University Press, 1990), p. 30; De Swaan, *In Care of the State*, pp. 7-8.

the institutionally-dependent individual.[27] While welfare states 'rationalise' society by redistributing risk, they transform personal responsibility for known or imaginable risks into blind participation in a larger web of risk which is beyond the capacity or control of the individual.[28] The welfare state is therefore an interesting framework of comparison for analysing changing conceptions of risk, and health risks are of particular interest on account of the status of salubrity as both a personal and a public asset.

Welfare state scholarship has been dominated by international comparative analyses, the most influential such effort being Esping-Andersen's specification of three varieties of welfare state; residual liberal, social democratic, and conservative corporatist.[29] While such typologies are of analytical use, their static character tends not to capture detail and divergence within and between nations, or welfare state evolution over time. Esping-Andersen resisted classifying Britain within his 1990 schema, in major part due to the distortion of its comprehensive health service in an otherwise residual policy structure.[30] Titmuss had earlier referred to the British welfare state as more generous and expansive in character, but by the end of the twentieth century most authors – including those working in the distinct but related 'varieties of capitalism' literature – describe Britain as liberal despite its National Health Service (NHS).[31] The task of complicating and particularising existing typologies to reflect the diverse experiences of different nations has been taken up by social scientists of all ilk, but a key role is played by historians in providing the detailed narrative evidence of welfare state evolution in different contexts. This dissertation contributes in some small way, within that area of social policy so confounding in the British case: health.

Specific analyses of health are underrepresented in the welfare state literature, and Esping-Andersen's ideal types are widely considered to be less incisive in comparisons of health care systems than in examinations of other types of welfare state services[32]. Attempts to link

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[27] Ulrich Beck, *Risk Society: Towards a New Modernity*, trans. Mark Ritter (London: Sage, 1992), pp. 128-30.
[28] Ibid, p. 228.
[29] Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Cambridge: Polity, 1990), pp. 26-7.
[30] Ibid, p. 53.
[31] Francis G. Castles and Herbert Obinger, 'Worlds, Families, Regimes: Country Clusters in European and OECD Area Public Policy, *West European Politics*, 31:1-2 (2008), p. 338; Sebastien Saint-Arnaud and Paul Bernard, 'Convergence or resilience? A hierarchical cluster analysis of the welfare regimes in advanced countries', *Current Sociology*, 51:5 (2003), p. 512; Jay Tate, 'National Varieties of Standardisation', in Peter A. Hall, David Soskice (eds.), *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage* (Oxford: Oxford University Press, 2001), p. 469.
[32] Wil Arts and John Gelisson, 'Three worlds of welfare capitalism or more? A state of the art report', *Journal of European Social Policy*, 12:2 (2002), pp. 145; Michael Moran, 'Understanding the welfare state: The case of health care', *British Journal of Politics and International Relations*, 2:2 (2000), p. 136.

typological analyses developed in the distinct body of health care systems literature with comparative welfare state scholarship more broadly have therefore been absent, with the outstanding exception of Rothgang et al's 2010 study of convergence in OECD health care systems since the 1970s.[33] Rothgang et al highlight the impact of structural adjustments in health care systems as 'indirect' forms of welfare privatisation, where funding is not directly slashed but emphasis shifts from government-run to voluntary and private services.[34] Their work demonstrates the need to consider both health care and welfare state structures in analyses of change. Britain and Germany are treated in the literature as model National Health System and National Health Insurance schemes respectively, both early pioneers of health and welfare policy and influential examples to later-developing welfare states.[35] These different structures, given different ideological underpinnings and mechanisms for managing risk, shape different ways of thinking about individual and social responsibility for health, and relationships between medical professionals, policy-makers, and public shape policy action. The first chapter of this dissertation begins with a comparison of the different structural and ideological underpinnings of the British and West German welfare states, which frames the comparison of attitudes to alcohol and tobacco health risks, as the remainder of the analysis charts the impact of neoliberalisation in the different regimes.

The effect of neoliberalism upon welfare state structures has produced a considerable body of work in politics and political economy, much of it polemical and defensive of welfare state institutions.[36] Recent work has shown that, in the period since 1975, most welfare budgets have actually expanded, and even accounting for the expense of an aging population, by measures of poverty and risk reduction, welfare states have become more 'generous'.[37] The previous section suggested that the spurious depiction of the neoliberal era as one characterised by the privatisation and scaling-back of welfare services masks a more 'hidden' processes of change; a transformation of the state's role, or re-calibration welfare state services through processes of

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[33] Heinz Rothgang, Mirella Cacace, Lorraine Frisina, Simone Grimmeisen, Achim Schmid, and Claus Wendt (eds.), *The State and Health Care: Comparing OECD Nations* (Palgrave Macmillan: 2010).
[34] Rothgang et al, *The State and Health Care*, p. 86.
[35] E.P. Hennock, *The Origin of the Welfare State in England and Germany, 1850-1914: Social Policies Compared*, (New York: Cambridge University Press, 2007), pp. 340-5.
[36] Jacob S. Hacker and Paul Pierson, *Winner-Take-All Politics: How Washington Made the Rich Richer – and Turned its Back on the Middle Class*, (New York: Simon and Schuster, 2010); Martha T. McClusky, 'Efficiency and Social Citizenship: Challenging the neoliberal attack on the welfare state', *Indiana Law Journal*, 78:2 (2003), pp. 783-876; Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment*, (Cambridge University Press, New York, 1994).
[37] Kees van Kersbergen and Barbara Vis, *Comparative Welfare State Politics: Development, Opportunities, and Reform* (Cambridge: Cambridge University Press, 2014), pp. 81-90.

policy 'drift' which subordinate social goals to public frugality and private profit.[38] Given the central role of health in social reproduction, changes in the definition of health risks, and conceptualisations of responsibility for health as resting with society, with individuals, or with families, affect our *experience* of welfare state structures, based on the rights and responsibilities for social reproduction which they confer. This dissertation contends that processes of neoliberalisation in public health have produced an experience of welfare state 'retrenchment' through the ideological – though not *actual* – 'privatisation' of responsibility for health risk management.

Content and structure

The dissertation seeks to examine the process of neoliberalisation in public health as evident in the definition of health risks and the framing of policy responses. It therefore attempts to identify the ways of thinking which shape the transmission of scientific knowledge into policy knowledge, and policy proposals; elements of the policy-making process which are difficult to capture, given the seclusion in which deliberation over public policy is conducted, and the tendency of politicians to make statements for political purposes, rather than necessarily in reflection of their personal perspectives. Gauging these ideas therefore involves interpretation of a variety of sources which reflect different audiences, purposes, and stages in the policy-making process. A close reading of English and German language parliamentary debates reveals how policy proposals are framed, and the kinds of ideas which inform debates over policy. That both *Hansard* in Britain, and the *Deutscher Bundestag Plenarprotokolle* are published verbatim for the entire period enables a fuller consideration of speakers' ideas – including ad-lib responses to interjections – than would a simple statement of position; and the length of the time frame covered allows for interpretation of statements in the context of claims made at other times, in an attempt to identify ulterior meanings or acts of political expediency. Of course, because the dissertation is principally concerned with how discourses reflect different and changing political cultures, what is politically expedient is in itself of interest. Effort has been made to distinguish widely-shared opinions from more unusual but relevant perspectives; and clearly biased discourses – for example, constructed by opposition parties in critique of government – are also identified.

The debates are supplemented with evidence from national government archives in London and Koblenz. Official reports and health education campaign materials are used to verify claims

[38] Jacob S. Hacker, 'Privatizing risk without privatizing the welfare state: The hidden politics of social policy retrenchment in the United States', *American Political Science Review,* 98:2 (2004), pp. 246-7.

made in parliament, and also to re-examine primary evidence referenced in secondary literature from a different perspective. Correspondence, memos, and the minutes of meetings provide evidence of actors' thinking often at an earlier stage in the policy-making process than views expressed in parliament, while publications and campaign material reflect a later stage, and are analysed to deduce purpose – particularly by comparison with prior, or later, documents of a similar nature. Significant interpretation is required when the stated aims of campaigns or policy strategies are questioned in parliament or in the secondary literature, and while care is taken to make an informed judgement, in some cases official sources are unavailable.[39] The author cannot capture all the factors influencing policy-makers' decisions; official sources reflect an image of the policy-making process deemed appropriate for potential public exposure. However, evidence considered certainly provides insight into policy-makers' framing of issues.

The dissertation also draws upon the archives of extra-governmental public health organisations and the papers of active individual experts and campaigners. Some of these groups and individuals are part of what Berridge has called the larger 'policy community', playing a significant role in shaping attitudes to health risks and informing policy responses by providing expert advice or lobbying the government from outside.[40] Ways of thinking about health risks within these organisations that contrast with – or do *not* influence – official attitudes at a particular point in time, are also of interest, revealing something about the political structures or cultures shaping policy-making. Here, the comparison between Britain and West Germany, characterised by different structural and ideological contexts, becomes particularly enlightening. Public health campaigners who are not a formal part of the policy community have different roles in each country, and influence discourses on new health risks in different ways. The dissertation uses these discourses around health risks, and the framing of policy responses to them, as a lens through which to compare the impact of different welfare state structures and ideologies upon the process of neoliberalisation in public health.

The first chapter of the dissertation addresses national differences between Britain and West Germany in the political structures which shape the translation of scientific knowledge into policy knowledge. As noted above, one of the principle aims of research by scholars such as Berridge and Nathanson has been to elicit the national specificities of relationships between medical scientists, the tobacco industry, and government that inform this process, to challenge

[39] For example, most of the German government archives on alcohol-related health education campaigns are organised into item folders covering long time periods which enter into the thirty-year exclusion period, rendering files on the 1960s and 1970s inaccessible at this time.
[40] Berridge, *Marketing Health*, p. 16.

globalist histories which generalise American experiences.[41] Existing work in the German context has already been principally concerned with explaining the nationally-specific factors shaping the 'backwardness' of German tobacco regulation, usually with reference to the history of health promotion during the National Socialist era.[42] Authors working on West Germany have been overwhelmingly condemnatory in tone, in describing the 'dearth' of medical scientific research by government and strong bargaining power of the tobacco industry, assured by corporatist governance structures and political donations.[43] To now, Rosemary Elliot has been the sole dissident voice, challenging the depiction of West German smoking policy as 'inward-looking' and ignorant of international scientific evidence. Elliot argues that policy responses reflected the liberal ideology of the *Soziale Marktwirtschaft* (Social Market Economy) rather than a resistance to intervention based on a memory of the Nazi past.[44] The first chapter of the dissertation joins Elliot in revising the depiction of West Germany as a tobacco-control laggard, by comparing the use of voluntary agreements with industry with the same policy tactic used in Britain. The transformation of official attitudes to tobacco from 1950 is contrasted with an ongoing but ambiguous suspicion about the potential dangers of alcohol consumption, reflecting different responses to scientific knowledge about alcohol. Chapter one therefore contributes to understandings of the social construction of perceived-as-objective knowledge, by comparing how the political structures and ideologies of the British and West German welfare states shaped conceptions and uses of 'expert' knowledge to the mid-1970s.

With the first chapter having established the differences between Britain and West Germany in the relationships between science, industry, and policy, the second chapter focuses on a common shift in both countries, referred to as the 'behavioural turn'. The behavioural turn is a transition toward what Alan Peterson and Deborah Lupton have called the 'new public health'; the management of personal health based on risk-factor epidemiology and behaviour modification.[45] The turn describes the *process* of change, and particularly the incorporation of psychological techniques to belie state management of individual behaviour under the guise of

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[41] Berridge, *Marketing Health*, pp. 11-12; Nathanson, *Disease Prevention as Social Change*, p. 11.
[42] George Davey Smith, Sabine Ströbele and Matthias Egger, 'Smoking and Health Promotion in Nazi Germany', Journal of Epidemiology and Community Health, 48 (1994), pp. 220-3; Robert N. Proctor, *The Nazi War on Cancer* (Princeton: Princeton University Press 1999), p. 288; Alice. H. Cooper and Paulette Kurzer, 'Rauch ohne Feuer: Why Germany Lags in Tobacco Control', *German Politics and Society*, 21 (2003), p. 39.
[43] Thilo Grüning, Christoph Strunck & Anna B. Gilmore, 'Puffing Away? Explaining the Politics of Tobacco Control in Germany', *German Politics*, 17:2 (2008), pp. 144, 158; Günter Frankenberg, 'Between Paternalism and Voluntarism: Tobacco Consumption and Tobacco Control in Germany', ch. 7 in Eric A. Feldman and Ronald Bayer (eds.), *Unfiltered: Conflicts over Tobacco Policy and Public Health* (Cambridge: Harvard University Press, 2004), pp. 177.
[44] Rosemary Elliot, 'Inhaling Democracy', p. 5.
[45] Peterson and Lupton, *The New Public Health*, pp. 19-21.

individual freedom. The chapter builds on recent work by Elliot, by re-examining primary evidence on the earliest tobacco health education campaigns in West Germany from 1962, providing new detail on their character to reveal a shift in strategy between the mid-1960s and late-1970s. This parallels a similar shift in Britain, where from the mid-to-late-1960s 'the new health educator was to be part salesman, persuading people to take appropriate action.'[46] In comparing policy-maker's attitudes to tobacco health risks with ideas about alcohol, the frame of 'actually existing neoliberalism' highlights how the political structures and ideologies of the British and West German welfare states shaped the available policy strategies in each context, in the process of a common behavioural turn.

Chapter three deals with ideas about tobacco and alcohol health risks and policy in the neoliberal era, from the mid-1970s, framing 'convergent' policy developments in Britain and West Germany in terms of the increasing relevance of international institutions, international scientific networks, and international 'benchmarking'. It discusses the impact of major changes in the scientific justification for both tobacco and alcohol control, in the shape of evidence on passive smoking and the introduction of 'recommended' alcohol units, demonstrating the ongoing complexities of the relationship between scientific and policy definitions of health risks. The management strategy of 'benchmarking', or setting external standards by which to measure policy, is depicted as a means of legitimating policies which, in practice, actually reflect the nationally-specific priorities of central governments; a contradiction between ideas and actualities identified by Isabelle Bruno and Emmanuel Didier as a feature of perceived-as-rational contemporary governance.[47] The chapter considers the use of benchmarking in Britain and West Germany, based on standards set by the World Health Organisation (WHO) and European Economic Community (EEC); organisations whose impact upon national alcohol policies has been identified as an important area for future research.[48] While the national-level focus of the dissertation makes the primary evidence unsuitable for a lengthy exploration of the topic, a contribution is made to the ongoing debate with particular reference to the impact of the EEC upon the use of punitive taxation. While international institutions reinforced neoliberal ideals of internationalisation and rationalisation, the experiences of neoliberalisation in Britain and West Germany were still significantly shaped by nationally-specific political structures and ideologies.

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[46] Berridge, *Marketing Health*, p. 74.
[47] Isabelle Bruno and Emmanuel Didier, *Benchmarking: State Bureaucracy under Statistical Pressure* (Paris: La Découverte, 2013).
[48] Virginia Berridge, Rachael Herring, and Betsy Thom, 'Binge Drinking: A Confused Concept and its Contemporary History', *Social History of Medicine*, 22: 3 (2009), pp. 603-4.

Chapter 1

Political structures, science, and industry

This chapter compares the relationships between medical scientific experts, public health lobbies, government, and industry groups, during the phase of construction and growth of the postwar welfare state in Britain and West Germany, to 1975. It contends that prevailing welfare state structures and ideologies affected the adoption of policy knowledge and formation of policy strategies in the two nations. Key differences can be identified in this period, in policy-makers' ways of thinking about tobacco as compared with alcohol, and in responses in Britain compared with West Germany. In Britain, the government became directly involved with research into tobacco health risks, but prior to the 1970s, not alcoholism. In West Germany, both were pursued by independent scientists, and the government did not cooperate with industry on tobacco research as closely as in Britain. Moreover, the federal government was not a site of health-related discussions with the drinks industries, as alcohol control legislation was the purview of the West German *Länder* (federal states). The chapter turns to focus more on tobacco in the discussion of industry, in order to address the dominant theme in the secondary literature, of tobacco industry power as a factor in government reluctance to action against smoking, especially in Germany. A comparison with the anti-smoking policies adopted in Britain reveals that, despite different ways of thinking about policy strategies, the voluntary agreements used in both countries in this period were strikingly similar. The depiction of West Germany as particularly backward during the 1950s to 1970s is therefore utterly inaccurate.

Postwar health and welfare

The political structures which emerged in Britain and West Germany from 1948 provided a framework within which policy-makers would think about and act upon health risks associated with alcohol and tobacco. This section summarises postwar developments in these structures, particularly as they related to health, to inform the discussion in the remainder of the dissertation. Britain's National Health Service (NHS) emerged in 1948 as a fairly significant break with the pre-existing structure of welfare funding and administration. The British state had a long history of intervention in health and welfare through legislation such as the Poor Laws, although funding and implementation were previously decentralised; delegated to local government or left to the voluntary sector. Though local authorities retained some administrative responsibility under the NHS, its centralisation and taxation funding represented

a major and enduring shift in British health policy.[49] The centralisation of health care had not, however, encompassed the work of public health, which remained localised under the oversight of Medical Officers of Health; the heads of local boards of health who had significantly steered local public health action since the mid-nineteenth century. [50] This administrative division between preventive and curative medicine, in the context of a Westminster-controlled funding system, was the bane of social medicine advocates in the 1950s to 1970s, inspiring controversial work by Thomas McKeown which denigrated the role of curative medicine in promoting health and well-being.[51] The government was connected with medical research through the Ministry of Health's influence with the formally-independent Medical Research Council (MRC), a scientific research body made statutory under the NHS, whose reputation was such that in 1950 the *British Medical Journal* reported that the body '[left] no side of medicine, preventive or curative, untouched'.[52]

The institution of the NHS was possible in Britain on the back of at least four decades of national centralisation of administrative power. The formerly permissive legislature, enabling of local health and welfare provision, had taken responsibility for ensuring (and insuring!) a salubrious national defence and work force following the drawn-out Boer war, and the exigencies of the First and Second World Wars, which had both legitimated central organisation of human and material resources, and provided an opportunity for a significant expansion of peace-time revenues.[53] Wartimes experiences, shared among diverse groups brought into direct contact by the disruption, arguably reinforced a sense of national community, while the advice provided to government by scientists and researchers during the wars made way for a more formal system of expert advisory committees afterward.[54] The national tax structure had been transformed during the interwar period to vastly expanded direct revenues from personal incomes, but indirect taxes remained reliable sources of revenue during the period of economic

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[49] Pat Thane, *Foundations of the Welfare State*, 2nd edition (London: Longman, 1996), p. 130.
[50] Berridge, *Demons*, p. 168.
[51] Simon Szreter, *Health and Wealth: Studies in History and Policy* (Rochester: Rochester University Press, 2005), p. 132.
[52] 'The Medical Research Council', *British Medical Journal,* 1: 4648 (4 February, 1950), p. 292.
[53] Graham Fennell, 'The Second World War and the Welfare State in Britain: Sociological interpretations of historical development', in Lynn Jamieson and Helen Carr (eds.), *State, Private Life, and Political Change*, (Basingstoke and London: Macmillan, 1990); Thane, *Foundations of the Welfare State*, p. 217.
[54] Robert E. Goodin, and John S. Dryzek, 'Risk-Sharing and Social Justice: The Motivational Foundations of the Post-War Welfare State', *British Journal of Political Science,* 16: 1 (1989), p. 11; Richard Titmuss, *Essays on the Welfare State* (London: Allen & Unwin, 1958), pp. 142-4; Virginia Berridge, 'Making Health Policy: Networks in Research and Policy after 1945', ch. 1 in Berridge (ed.), *Making Health Policy: Networks in Research and Policy after 1945* (Amsterdam: Rodopi, 2005), p. 9.

recovery.[55] The tobacco duty was increased in 1947 to raise revenue from what was seen as the price-inelastic demand for tobacco products in a culture where smoking was 'normal', and non-smokers – who, the government estimated, comprised about 15% of the population – considered 'unusual' and 'abnormal'.[56] In April 1950, a doctor MP specialising in pulmonary diseases suggested that non-smokers might be suffering from health *defects*, perhaps 'peptic ulceration or minor forms of dyspepsia', precluding them from the enjoyment of cigarettes.[57]

Postwar health care in West Germany was characterised by greater continuity, with a return to the contributory system by which statutory health insurance had been organised since 1883, but the new political structures which emerged from the unification of the three Western Allied occupation areas established a particular federal, corporatist arrangement which shaped health and welfare policy for the rest of the century. The decentralisation directive of the Potsdam Agreement had left the new West German state without a centralisation of power or resources comparable to that of the British government.[58] In addition, the continuation of corporatist health insurance administered by sickness funds was advocated by the *Länder*, whose political power had been strengthened under the new federal system.[59] The foundational *Grundgesetz* (Basic Law) of 1949 was grounded in an historical precedent of corporatism, conservative catholic values, and the ideas of the Freiberg school of economic thought which emphasised the social foundations of economic prosperity.[60] The *Grundgesetz* prioritised the 'dignity' of the individual and their personal development (Articles 1 and 2), the protection of children and the family (Article 6), and conferred the right to organise into associations and corporations (Article 9).[61] The West German variant of corporatism promoted the flourishing of the individual *within* the community. Although West German welfare was informed by the catholic family ideal, the family was not, as in corporatist Southern European regimes, viewed as a 'social shock absorber' or 'welfare broker' for its members.[62] Solidarity was founded on common security.

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[55] Martin Daunton, *Just Taxes: The Politics of Taxation in Britain, 1914-1979* (Cambridge: Cambridge University Press, 2002), p. 218.
[56] Hansard, **'**Restaurant Cars (Non-Smokers)', Parliamentary debates, 473 (3 April, 1950), cc. 950-76.
[57] Ibid, c. 958.
[58] Armin Grünbacher, *The Making of German Democracy: West Germany during the Adenauer era, 1945-1965* (Manchester: Manchester University Press, 2010), p.64.
[59] Arthur Gunlicks, *The* Länder *and German Federalism* (Manchester: Manchester UP, 2003), pp. 28-32.
[60] Werner Abelhauser, 'Erhard oder Bismarck? Die Richtungsentscheidung der deutschen Sozialpolitik am Beispiel der Reform der Sozialversicherung in den Fünfziger Jahren', *Geschichte und Gesellschaft*, 22:3 (1996), pp. 378-81; Steen Mangan, 'The German Social State, 1949-1989: A Selective Critique', in Eva Kolinsky (ed.), *The Federal Republic of Germany: The End of an Era* (Oxford: Berg, 1991), p. 221.
[61] Deutscher Bundestag, *Grundgesetz für die Bundesrepublik Deutschland* (Bonn: Deutscher Bundestag, 1949).
[62] Maurizio Ferrera, 'The South European Countries', in Francis G. Castles, Stephan Leibfried, Jane Lewis, Herbert Obinger, and Christopher Pierson (eds.), *The Oxford Handbook of the Welfare State* (Oxford: Oxford University Press, 2010), p. 622.

The influence of West German constitutional culture upon alcohol and tobacco policy can be observed in parliamentary debates as early and 1949-50. In contrast to Britain, where both tobacco and alcohol duties accrued to the central government, tobacco was regulated by the West German federal government to manage its trade, but the tax on beer was administrated by the *Länder*. The right of individual *Länder* to set beer taxes was granted following a claim by the Bavaria Party[63] that federal taxes fell disproportionately upon Bavarians, due to a cultural difference; 'If Bavaria drinks more beer per head than elsewhere, it is because we do not like lemonade as much as you like it elsewhere', it was argued.[64] The debate was waged in terms of *Grundgesetz* Article 72, which gave *Länder* law primacy in the event of competing federal legislation, unless the latter was in the interests of equalising inter-state living standards.

The National Health Insurance system which emerged within the federal constitutional structure of postwar West Germany gave significant power to physicians in private practice, whose professional independence from the sickness funds and government-funded hospitals was defended under the rights to occupational freedom (Article 12) and corporatist negotiation (Article 9), allowing them to establish a virtual monopoly over out-patient care from 1955.[65] Hospitals were administered by the *Länder,* but subsidised substantially by the federal government until 1972, and the operation of sickness funds regulated at both federal and state level (in accordance with Article 72), in negotiation with national and regional associations of physicians and sickness funds. There is a strong consensus in the literature that the separation of out-patient care from public facilities caused the neglect of preventive and social medicine.[66] Medical research in hospitals and private facilities was regulated by the *Länder*, many of the Reich bodies for medical research having been broken up in the Allies' 'denazification' process.[67] The federal government remained withdrawn from regulating research, further empowering *Länder* to approve medicines in the 1961 Medicine Law.[68]

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[63] A small conservative party advocating Bavarian nationalism; formerly part of the Bavaria People's Party (*Bayerische Volkspartei*), together with the Christian Social Union of Bavaria, prior to the Second World War.
[64] Deutscher Bundestag, Plenarprotokolle, 1/22 (9 December, 1949), pp. 704-5.
[65] Michael Moran, 'Health Care Policy', ch. 4 in Jochen Clasen and Richard Freeman (eds.), *Social Policy in Germany* (London: Harvester Wheatsheaf, 1994), p. 88.
[66] Moran, 'Health Care Policy', p. 94; Peter Rosenberg, 'The Origin and Development of Compulsory Health Insurance in Germay', ch. 4 in Donald W. Light and Alexander Schuller (eds.), *Political Values and Health Care: The German Experience* (London: MIT Press, 1986), p. 124; Stefan Kirchberger, 'Prävention als Aufgabe der Gesundheitspolitik: Überlegungen zur Umgestaltung der Arbeitgeberbeiträge in der gesetzlichen krankenversicherung', *Politische Vierteljahrschrift,* special issue 9 (1978), pp. 222.
[67] Moran, 'Health Care Policy', p. 91.
[68] *Bundesgesetzblatt*, 33 (9 May, 1961), pp. 539-41.

Policy knowledge and medical science

As a result of the postwar welfare state structures which emerged in Britain and West Germany, curative rather than social and preventive medicine became the primary focus of both national governments, but the West German federal government was more removed from medical scientific research than Westminster. Doll and Hill's work on the link between smoking and lung cancer, published in September 1950, had been facilitated from early 1948 by the MRC, who organised patients for the study from London hospitals.[69] Doll and Hill's statistical epidemiological methods were not typical of the principally biological-scientific inquiries undertaken by the MRC itself. When the association between smoking and lung cancer was first asserted, the British government's immediate response was to encourage the MRC to investigate its biological foundations. [70] In 1954, then Minister for Health, Ian Macleod, wrote that although the statistical evidence implied a causal link, it was 'not yet proven' by research into carcinogenic substances.[71] The kinds of research techniques being used, especially animal testing, were innovative and challenging; 'modern' scientific methods which demanded regulation by government. The debates on these techniques reflect a conception of cancer, too, as a 'modern' scourge, associated with the 'stresses' of contemporary urban life, of which increased alcohol and tobacco consumption was also a part. [72] The British government defended animal testing on the recommendation of the MRC. [73]

In 1962, a West German parliamentary commission specifically recommended animal testing as a route for improving knowledge about the cause of lung cancer.[74] The Commission's report responded to the 1962 report by the British Royal College of Physicians (RCP), *Smoking and Health*, which had made no such recommendation.[75] West Germany had no organisation like the MRC, in its stature, capacity, and closeness to government. The Federal Health Agency, responsible for public health monitoring, and the German Research Foundation, charged with the approval of federal government funding for independent research, lacked institutional capacity after their reconstitution in 1951. Animal testing was conducted and funded by the Association of the Cigarette Industry (VdC). In a letter to the Federal Minister for Health in 1962, the president of the Federal Health Agency suggested that in order to bring the health

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[69] Richard Doll, 'The First Reports on Smoking and Lung Cancer', in S. Lock, L.A. Reynolds and E.M. Tansey (eds.), *Ashes to Ashes: the History of Smoking and Health* (Amsterdam: Rodopi, 1998), p. 133.
[70] Hansard, 'Cancer', Written answers, 494 (6 December, 1951) cc. 295-6W.
[71] Hansard, 'Smoking and Lung Cancer (Committee's Report)', Written answers, 523 (12 February, 1954), c. 173W.
[72] Hansard, 'Vivisection (Cancer Research)', Parliamentary debates, 480 (31 October 1950), cc. 139-46.
[73] Ibid, c. 150.
[74] Elliott, 'Inhaling Democracy', p. 8.
[75] Royal College of Physicians, *Smoking and Health* (London: Pitman, 1962).

risks of smoking to the forefront of the VdC research, networks could be made with the German Research Foundation, the *Max-Planck-Gesellschaft* (a leading independent research society), or 'even a part of the Federal Health Agency', but the possibility of central government research into smoking and health was ruled out.[76]

The dominance of biological science as a form of evidence for policy in the 1950s was also reflected in responses to alcohol risks, although both British and West German governments understood these dangers in terms of the 'disease' model of alcoholism, as a mental illness, without implying a risk from alcohol consumption in general. The WHO had declared alcoholism a 'disease' in 1951, in line with the model designed by prominent researcher, E. Morton Jellinek. Jellinek emphasised in 1954 that alcoholism should be just one part of the public health agenda around broader 'alcohol problems', but alcoholism remained the focus of most governments into the 1970s.[77] The primary alcohol-related risk with which the British government was concerned prior to the 1970s, was that of the drunk driver. The MRC conducted biological research from the 1950s into the effects of alcohol on the body, in order to gauge its impact upon driver skills and responses.[78] This research informed the new Road Safety Act of 1967, which permitted breath testing of any driver suspected of being over the limit of 80mg per 100ml (0.08) blood alcohol content (BAC). The design and trialling of breath testing devices also fell upon the MRC.[79] Medical scientific researchers and central government in Britain were structurally closer than in West Germany, and the relationship with the MRC contributed to the emphasis in the 1950s and 1960s on the biological underpinnings of health risks.

Lobby groups, science, and policy

The public health groups interested in alcohol and tobacco had different relationships, in Britain and West Germany, with government and medical science. The West German government were criticised, by both the opposition and outside organisations, for lack of spending on alcohol research. In July 1950, the German Agency against the Dangers of Addiction (DHS), a non-governmental research institution, wrote to the office of Chancellor Adenauer, describing both alcohol and tobacco as '*Gesnussgifte'*, consumption items that were not only unnecessary, but whose over-consumption would 'inevitably burden the nation as a whole with far-reaching

[76] Bundesarchiv, Bundesgesundheitsamt, B 310/302, 'Der Präsident des Bundesgesundheitsamtes an den Herrn Bundesminister für Gesundheitswesen', 16 September 1962.
[77] Robin Room, 'The World Health Organisation and Alcohol Control', *British Journal of Addiction*, 79 (1984), p.86.
[78] Hansard, 'Alcohol and Road Accidents', Parliamentary debates, 212 (4 November, 1958), c. 140.
[79] Hansard, 'Breath Tests', Written answers, 754 (15 November, 1967), cc.135-7W.

damage'.[80] The letter connected habitual drinking with reduced productivity and premature death, and tobacco abuse with causes of death such as heart disease and cancer. Statistical evidence on the link between smoking and lung cancer had been published only three months prior in America, and the British Doll and Hill evidence was yet to be released. The Germans had been among the first to conduct biological research into the health risks of smoking through during the National Socialist era, building on government interest in medical scientific investigation fostered during the Weimar years, but in the Federal Republic such government research had waned.[81]

The DHS also lobbied members of the *Bundestag* directly, sending an open letter, on behalf of the numerous local public health groups and research institutes that it cooperated with, to the *Bundestag* delegates in December 1952. The letter citied the findings of German and international scientific experts on the dangers of both alcohol and tobacco, and protested the planned lowering of the tobacco tax on public health grounds. [82] Rosemary Elliot has observed that this clearly had an effect on the representatives, as the early-1953 debates on changes to the tobacco tax considered the health implications.[83] Overwhelmingly, though, the consumption of tobacco, like other *Genussmittel* such as wine, was depicted as unproblematic 'in moderation', and popular education to that effect was considered best left to those responsible for providing individuals with 'the tools to preserve their own moral standing'…'entirely different people from the Finance Minister'.[84] It is worth noting that in West Germany, the price of tobacco, influenced by taxation, was openly stated as having an impact on consumption, while British politicians depicted tobacco as a relatively price-inelastic good.[85]

While the DHS used medical scientific evidence to lobby the national government on both tobacco and alcohol, in Britain during the 1950s and 1960s interactions between government and lobby groups with regard to tobacco were rather different concerning alcohol. The lobbying activities of the Royal College of Physicians (RCP) on smoking have been well documented by Virginia Berridge.[86] In particular, Berridge emphasises the new approach by medical

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[80] Bundesarchiv, Bundeskanzleramt, B136/5280, slide 1, letter from Seidel to Adenauer, 17 July 1950.
[81] Smith et al, 'Smoking and Health Promotion in Nazi Germany', pp. 220–3.
[82] Deutscher Bundestag, Plenarprotokolle 1/259 (15 April, 1953), pp. 12576-7.
[83] Rosemary Elliot, 'Smoking for Taxes: The triumph of fiscal policy over health in postwar West Germany, 1945-55', *Economic History Review*, 65: 4 (2012), p. 1463.
[84] Deutscher Bundestag, Plenarprotokolle, 1/259 (15 April, 1953), pp. 1257-85.
[85] Hansard, 'Budget Proposals and Economic Survey', Parliamentary debates, 449 (12 April, 1948), cc.729-30; 'Reduction of Duties on Beer', Parliamentary debates, 446 (22 June, 1949), cc. 235-6; 'Budget Proposals', Parliamentary debates, 514 (15 April, 1953), c. 308.
[86] Virginia Berridge, 'Medicine and the Public: The 1962 Report of the Royal College of Physicians and the New Public Health', *Bulletin of the History of Medicine*, 81: 1 (2007), pp. 286 – 311.

professionals of speaking directly to the public, using the mass media; especially television counter-advertising, and the lay press.[87] The RCP's report had effectively issued a public petition to government, to 'provide a clear declaration of Parliament's concern about the dangers of the habit', a charge which would remain in policy-makers' minds, appearing in debates a full decade later.[88] Into the 1970s, the chief pressure group for tobacco was Action on Smoking and Health (ASH), established in 1971 by the RCP, and funded approximately 90% by the Department of Health and Social Services (DHSS).[89] According to Berridge, ASH's role as an 'insider-outsider' organisation was to act as a kind of national council for research and information, while also pressuring government from the outside, as justification for Ministry of Health action.[90]

In contrast with the mass media approach of the RCP, and later ASH, research and lobby groups for alcohol in Britain targeted their efforts at the population through the general practitioner, working more deliberately within the framework of the NHS. [91] One of the main actors in alcoholism treatment and research during the 1950s and 1960s was the alcoholism steering group of prominent charitable organisation, the Joseph Rowntree Trust. Betsy Thom has briefly the Rowntree group as appearing to have established itself as a 'support group' for local alcoholism treatment clinics from the mid-1950s, promoting awareness of alcoholism symptoms and treatments to general practitioners.[92] A comparison of the Rowntree group's activities with those of DHS in West Germany, and fuller exploration of its role, is enhanced here by new evidence including full meeting minutes from the paper of Sir W. Allen Daley; building on Thom's analysis of the agendas and correspondence of the group's chair. Like the DHS, the Rowntree group cooperated with a large number of local research organisations and voluntary groups, as well as university medical schools, and social science departments.[93] However, while the DHS lobbied the government for action on alcoholism treatment, the Rowntree group communicated directly with GPs, whom they viewed as the main target to

[87] Berridge, 'Medicine and the Public', p. 300.
[88] Hansard, 'Cigarettes (Prohibition of Advertising)', Parliamentary debates, 829 (19 January, 1972), c.489.
[89] Berridge, *Marketing Health*, pp. 164-7.
[90] Berridge, *Marketing Health*, pp. 146-8, 176, 182; Berridge, 'Science and Policy', pp. 152-3.
[91] Wellcome Library, Sir (William) Allen Davey papers, PP/AWD/H/6/30, Joseph Rowntree Trust Steering Group on Alcoholism, Minutes of a meeting, 21 March 1963, p. 2.
[92] Betsy Thom, *Dealing with Drink. Alcohol and Social Policy: From Treatment to Management* (London: Free Association Books, 1999), p. 79-81.
[93] Wellcome Library, Sir (William) Allen Davey papers, PP/AWD/H/6/2, Joseph Rowntree Trust Steering Group on Alcoholism, Minutes of a meeting, 11 December 1958, p. 1.

'influence an active sense of responsibility' in alcoholics to reform.[94] The DHS could also have communicated with physicians through national or local associations, but they chose to focus their lobbying efforts upon policy-makers. The main difference between practitioners in Britain and in West Germany was the professional power, and payment by capitation, of the latter, providing little incentive to engage in preventive or social medicine. Private physicians became the target of alcohol and tobacco health information from another organisation with which the DHS worked, to be discussed in chapter two, on health education.

In Britain the Rowntree group was interested, at least as much as in treating alcoholism, in supporting services so that larger numbers of the affected population would come forward, to allow research into disease incidence and correct for what seemed to be an 'incidental' prominence among both convicted criminals and higher income groups; those who were able, through institutionalisation or their own means, to seek treatment.[95] Surveys were commenced at Rowntree-sponsored centres across the country from 1959, expanding rapidly in the early 1960s.[96] This survey work can be viewed in the context of the shift from biological inquiry toward more statistical epidemiological analysis, of which the work on tobacco was also a part. That the Rowntree group were pursuing such work in the late 1950s and early 1960s suggests that this development in the alcohol field was simultaneous with, rather than, as Berridge has suggested, 'an unexpected side effect' of, developments in tobacco research.[97] That these statistical techniques were not reflected in the MRC's work on alcohol in the 1960s – which remained biologically-based, in relation to drink-driving – reflects the fact that alcohol treatment and research remained largely the purview of voluntary organisations into the 1970s.[98] The Rowntree group, following the work of Jellinek, was also interested in observing the broader problems of alcohol consumption, not yet depicted in policy-makers' definitions of health risks at the time.[99] The Rowntree group worked with brewing and pub company, Whitbread, on statistical research into 'group' and 'problem' drinking from the early 1960s.[100]

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[94] Wellcome Library, Sir (William) Allen Davey papers, PP/AWD/H/6/2, Joseph Rowntree Trust Steering Group on Alcoholism, Minutes of a meeting, 11 December 1958, p. 3.
[95] Ibid, pp. 2-3.
[96] Thom, *Dealing with Drink*, pp. 80-1, 179; Wellcome Library, Sir (William) Allen Davey papers, PP/AWD/H/6/6, Joseph Rowntree Trust Steering Group on Alcoholism, Minutes of a meeting, 28 May 1959, p. 3; PP/AWD/H/6/26-7, Joseph Rowntree Trust Steering Group on Alcoholism, Minutes of a meeting 12 July 1962, 24 July 1962.
[97] Berridge, *Demons*, p. 5.
[98] Thom, *Dealing with Drink,* p. 72; Hansard, 'Alcoholism', Parliamentary debates 358 (19 March, 1975), c.818.
[99] Thom, *Dealing with Drink*, p. 81.
[100] Wellcome Library, Sir (William) Allen Davey papers, PP/AWD/H/6/18, Joseph Rowntree Trust Steering Group on Alcoholism, Minutes of a meeting, 7 March 1961, p. 1.

It was not until the 1970s that the British government became more directly involved in alcoholism treatment and broader alcohol research, providing funding for research and coordinating community facilities.[101] The DHSS made a 'substantial grant' to the Medical Council on Alcoholism[102] early in the decade, the Addiction Research Unit of the Institute of Psychiatry carried out state-funded treatment research, and £2 million was invested in NHS- and voluntary-run treatment facilities.[103] At the same time, broader issues of 'problem' drinking became more prominent in the medical press.[104] The growing influence of psychological science saw the government concerned to accrue more evidence about the origins of alcoholism and 'problem drinking'; supporting research into student attitudes to alcohol consumption.[105] The connections between public health lobbies and scientific research institutes grew with government investment and interest, and the establishment of new national committees as expert advisory bodies.[106] Broader ideas about alcohol health risks were incorporated into policy knowledge influenced by new ideas from psychology, as well as interactions with the World Health Organisation, to be discussed in chapter three.

New psychological ideas about childhood stress and habit-forming behaviours existed alongside developing psychiatric theories of addiction and physical dependence, informing conceptions of both alcohol and tobacco health risks into the 1970s. In Britain, smoking withdrawal clinics modelled on specialist clinics for alcohol and drug addiction were established, primarily by voluntary organisations, in the 1960s.[107] These were expanded after the RCP's second report, *Smoking and Health Now* (1971), introduced the first evidence on nicotine as an 'addictive' substance operating on smokers who were also psychologically 'dependent' on the 'habit'.[108] Scientific evidence on the addictiveness of nicotine corroborated ideas about 'enslavement' to cigarettes which had informed British policy-makers' thinking since the early 1950s.[109]

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[101] Wellcome Library, Max Meier Glatt papers, PP/MXG/B/1, 'Alcoholism: the British Scene', address by B.D. Hore to the 20th International Institute on Prevention on Prevention and Treatment of Alcoholism, 1974; Society of Medical Officers of Health archive, SA/SMO/J/5/2a, 'Statutory Services for Problem Drinkers', Dr R. J. Wawman at the symposium Alcohol Abuse is a Community Health Problem – Who can help?, 17 January 1985.
[102] An organisation of doctors established in 1967 to educate practitioners, physicians, and medical students about alcoholism, and to support current research.
[103] Hansard, 'Alcoholism (Treatment)', Parliamentary debates, 854 (3 April, 1973), c.210; 'Licensing Compensation Fund', Parliamentary debates, 376 (2 November, 1976), c. 1076.
[104] Wellcome Library, Max Meier Glatt Papers, PP/MXG/D/2/1, 'Cuttings. Alcohol and alcoholism: Medical and other professional publications'.
[105] Hansard, 'Alcoholism', Parliamentary debates, 358 (19 March, 1975), c. 784; 802.
[106] Thom, *Dealing with Drink*, pp. 81-2.
[107] Berridge, *Marketing Health*, pp. 249-51.
[108] Royal College of Physicians, *Smoking and Health Now* (London: Pitman, 1971), pp. 39-41.
[109] Hansard, 'National Health Service Bill', Parliamentary debates, 176 (6 May, 1952), c. 621.

Smoking was already being described in parliament as a 'powerful addiction' in 1967.[110] In West Germany, nicotine was named as the active drug in tobacco smoke throughout the 1950s and 1960s, and although not described as 'addictive' until the 1970s, the difficulty of giving up was mentioned, and nicotine depicted as a 'poison' as early as 1953.[111] Clinics for tobacco and alcohol withdrawal remained almost exclusively voluntary even into the 1970s; as a consequence of the division between hospital and ambulatory care, out-patient treatment for psychological and psychiatric services was not well provided.[112] As the West German government came under increasing pressure in the mid-to-late-1960s for a lack of funding for research into tobacco and alcohol, the Minster for Health emphasised instead health education programs – the subject of the following chapter – as the preferred method of action.[113] The incorporation of new psychological science into policy knowledge in West Germany was shaped by efforts to design such health education campaigns. While both the British and West German governments responded to newly-identified health risks and new scientific frameworks, the networks of transmission varied in each context, shaping policy knowledge, and policy responses as well.

Industry and advertising

Government relationships with science have followed government relationships with industry as the primary explanatory factors in much of the secondary literature on tobacco control policy, with West Germany depicted as particularly laggard on account of the political power of tobacco companies.[114] This author has not investigated industry archives or correspondence with industry, so will not attempt a detailed reassessment of government relationships with industry, but this section draws from secondary literature and parliamentary debates in each context to directly compare the steps taken in Britain and West Germany in cooperation with industry during the 1960s and 1970s, and to consider the broader ideas about industry and economy which affected the use of voluntary agreements as policy tools at this time.

In 1965, both Britain and West Germany negotiated voluntary agreements with tobacco industry associations to control television advertising. In West Germany, advertising directed at

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[110] Hansard, 'Health Education', Parliamentary debates, 287 (20 December, 1967), cc. 1464-553, 1505.
[111] Deutscher Bundestag, Plenarprotokolle, 1/259 (15 April, 1953), p. 12580.
[112] Peter Rosenberg and Maria Elizabeth Ruban, 'Social Security and Health-care Systems', ch 8 in Donald W. Light and Alexander Schuller (eds.), *Political Values and Health Care: The German Experience* (London: MIT Press, 1986), p. 281.
[113] Deutscher Bundestag, Plenarprotokolle, 4/109 (24 January, 1964), pp. 5027-9; Plenarprotokolle 5/224 (26 March, 1969), p. 12273-85.
[114] Grüning et al, 'Puffung away', p. 142.

young people was to avoid imagery of vitality, sporting success, or anything deemed to appeal to children, and advertising would eventually be removed from television (realised by 1971), but not from billboards or printed press. [115] Although the *Bundesrat* (representing the *Länder*) had preferred a total ban on advertising, the latter suggestions were shelved, according to Elliot, as the Federal Cartel Office saw them as unjustified on health grounds, and therefore in violation of the 1957 Law against Restraints on Competition.[116] The highly legalistic nature of these disputes, demanding conciliatory cooperation, reflects the *Rechtsstaadt* mode of governance set out by the *Grundgesetz* and underpinning West Germany's welfare state structure.[117] The 1965 agreement in Britain extended a 1962 accord, which had stipulated that, 'There must be no over-emphasis on pleasure from smoking; advertisements must not feature heroes; there must be no appeal to manliness or pride; they must not suggest that it is fashionable or "go-ahead" or exciting to smoke', and that advertising be banned from television before 9pm.[118] In 1965, television advertising was barred. The remarkably similar agreements reached in Britain and West Germany in 1965 would seem to allay suspicions of Germany being particularly laggard in acting on tobacco health risks; more evidence to this effect will be provided in the following chapter.

The kinds of relationships between government and industry which these agreements represented have been fruitfully debated in the secondary literature. David Collingridge and Colin Reeve have argued that the voluntary agreements in Britain represented a strategic power-grab by industry, who gained 'direct access to the government's thinking', suggesting that the industry only ceased promoting a competing genetic-predisposition theory linking smoking and lung cancer because this alternative strategy became available.[119] In Germany, the VdC had been hugely successful in lobbying for tax reductions to protect local tobacco growers and manufacturers, defending, in the terms of the *Grundgesetz*, individual workers' 'dignity', and evoking the disastrous personal and social effects of factory closures in Westfalen, Baden, and Hessen.[120] Elliot argues that the finance minister's 'pragmatic' suggestion that more funds could be directed into health education to reconcile the health impacts of a tax reduction, was just as politically significant as the symbolism for the Adenauer government of protecting the tobacco

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[115] Deutscher Bundestag, Plenarprotokolle, 6/144 (20 October, 1971), p. 8264.
[116] Elliot, 'Inhaling democracy', p. 12.
[117] Kenneth Dyson, 'Theories of Regulation and the Case of Germany: A Model of Regulatory Change', ch. 1 in Dyson (ed.), *The Politics of German Regulation* (Aldershot: Dartmouth, 1992), pp. 12-13.
[118] Hansard, 'Cigarettes (Prohibition of Advertising)', Parliamentary debates, 829 (19 January, 1972), c.490.
[119] David Collingridge and Colin Reeve, *Science Speaks to Power: The Role of Experts in Policy Making* (London: Frances Pinter, 1986), pp. 123-39.
[120] Elliot, 'Smoking for taxes', pp. 1457-9.

manufacturers and growers, who were considered among the middle-class family businesses so culturally significant in German society.[121] Berridge suggests that in Britain, while revenue from the tobacco duty and the power of the industry were meaningful, the voluntary agreements of the 1960s and 1970s were shaped by changing evidence bases and ideologies of public health more than an 'alliance' with industry.[122] Constance Nathanson has argued that voluntary agreements reflected not the subservience of public interest to corporate power, but an historical preference for the 'gentleman's agreement' over direct legislation in liberal Britain.[123] In West Germany, they represented the most constitutionally-sanctioned method of governance. The use of voluntary agreements with industry was clearly shaped by more complex structural and ideological factors in both Britain and West Germany than simply corporate power or government dependence on taxation revenues.

Pertinent to this dissertation's analysis of changing ways of thinking about tobacco and alcohol health risks, is a consideration of the broader ways of thinking about industry and economy which shaped these agreements, and other policy responses. Agreements with industry in both Britain and West Germany sought to control advertising, but policy-makers' conception of advertising differed between nations. In Britain, children were seen as particularly vulnerable to the 'very great and powerful medium of television' as a new, modern form of media.[124] The regulation of this new medium presented a challenge for the role of government, as had the regulation of modern research techniques. Policy-makers' attitudes in the 1950s suggested, at least in relation to alcohol, that advertising did not persuade people to drink, but persuaded people who liked to drink, to drink a particular *kind* of drink.[125] Collingridge and Reeve have suggested that the discourse of advertising promoting brand-switching rather than the taking-up of smoking was initiated by industry in negotiations during the 1960s,[126] but the same logical premise had clearly already been expressed by public officials. By the 1960s, policy-makers' concern was that advertising directed at youth could encourage them to pick up a brand before they had started.[127] That children were recognised as particularly at risk would become important in the definition of smoking risks, and framing of policy responses, in the coming decades.

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[121] Elliot, 'Smoking for taxes', p. 1470.
[122] Berridge, *Marketing Health*, p. 35.
[123] Nathanson, *Disease Prevention as Social Change*, p. 198.
[124] Hansard, 'Television Bill', Parliamentary debates, 528 (31 May, 1954), c. 953.
[125] Ibid, cc. 958-9.
[126] Collingridge and Reeve, *Science Speaks to Power,* p. 138.
[127] Hansard, 'Smoking and Tobacco Advertising', Parliamentary debates, 646 (18 October, 1961), c. 328; 'Lung Cancer', Parliamentary debates, 737 (9 December, 1966), c. 1727.

In West Germany, there was little discussion in parliament about the economic role of advertising in the 1960s, and Elliot's work suggests that negotiations of the 1965 agreement are difficult to trace in the archives.[128] However, that health education campaigns from the late-1960s taught school children to 'de-code' tobacco advertising (a topic which will be elaborated in the following chapter) suggests that, although a degree of advertising was necessary to facilitate competition and uphold anti-cartel legislation, the role of advertising as market information was not superior to the need both to protect children, and to allow the free flourishing of individuals; the key rights prioritised in the *Grundgesetz*. The role of the state was to 'restrict [commercial] freedom in order to protect the weak from the interests of businessmen'; the mandate of the *soziale Rechtsstadt*.[129] When the 1974 *Lebensmittelgesetz* (Food Law) replaced the 1965 voluntary agreement, legislating further restrictions upon advertising to prohibit any health claims, the bill was presented as one of 'preventive health' and 'consumer protection'.[130] A single Christian Democratic Union (CDU)[131] representative spoke out against the 'left-wing' conception of advertising as propaganda, arguing that it provided market information and played a key role in economic growth, but this was not the dominant view.[132]

In comparison, the role of advertising as market information gained new significance in Britain into the 1970s, as the government conducted joint research with the tobacco industry into the possibility of safer smoking or 'New Smoking Material' (NSM).[133] In order for the release of such products into the market to facilitate a reduction of overall harm from smoking, consumers required information about the harm levels of different products. Minister for Health, David Owen, stated that banning advertising altogether would make changing to safer brands more difficult to achieve.[134] The 'harm reduction' strategy saw a new voluntary agreement negotiated in 1971, which allowed nicotine- and tar-level testing to be conducted by the Consumers' Association, with results available for advertising, and published as a 'league table' in newspapers.[135] Cigarette packets would also read the warning, 'smoking can damage your

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[128] Elliot, 'Inhaling democracy', p. 10.
[129] Deutscher Bundestag, Plenarprotokolle, 6/105 (5 March, 1971), pp. 6130-1.
[130] Deutscher Bundestag, Plenarprotokolle, 7/108 (18 June, 1974), pp.7308-11; 7322-5.
[131] CDU refers henceforth to the coalition of the Christian Democratic Union and Christian Social Union parties in the *Bundestag*; the latter operating only in Bavaria as a sister-party of the CDU after WWII.
[132] Deutscher Bundestag, Plenarprotokolle, 7/108, (18 June, 1974), pp. 7307.
[133] For discussion of NSM research with the tobacco industry see: Berridge, *Marketing Health*, pp. 142-6.
[134] Hansard, 'Smoking and Health', Parliamentary debates, 903 (16 January, 1976), c. 803.
[135] Wellcome Library, Max Meier Glatt papers, PP/MXG/D/2/1, clipping from *The Sun,* 9 September 1971, p. 7.

health'.[136] NSM 's failure to succeed in the market, or indeed prove very safe, culminated with the Health Education Council (HEC) describing 'safer cigarettes' as 'jumping from the 36th rather than the 39th floor' in 1978.[137] Packet warnings and tar-level testing remained, however, and 'harm reduction' was to be revisited in the shape of differential taxation; to be discussed in the final chapter of the dissertation.

'Harm reduction' was never a strategy of policy in West Germany, despite an awareness of activities in Britain, because the government was not involved in financing or carrying out 'safer smoking' research; resources spent by the industry and private finance were considered to be 'sufficient'.[138] Advertising was not, therefore, conceived of as playing the same informative role as in Britain. Although both British and West German politicians had referred to tobacco industry advertising as 'propaganda', neither viewed advertising as severely as Allen Brandt has depicted it in hindsight, as *constraining* of individual choice[139] – with the exception of the choices of children.

The British government could be described as much closer to the tobacco industry than that of West Germany, as a result of its work with industry scientists on NSM in the 1960s and 1970s. While the West German government protected workers in the industry, and sought to uphold a degree of market 'freedom',[140] the British government invested in research which would have furthered the financial interests of the industry, *had* NSM been a success – a distinctly private-profit-oriented move not sufficiently highlighted by Berridge. The structures of the West German welfare state also meant that the federal government was more distanced from medical scientific research than in Britain. In 1974, West Germany turned to hard legislation in the form of the *Lebensmittelgesetz* (Food Law), and by 1976 David Owen suggested that the voluntary agreements in Britain, too, had not gone far enough, reflecting a new phase of 'hostility to industry' which Berridge describes as characteristic of public health from the 1970s.[141] The similarity between British and West German voluntary agreements prior suggests that the characterisation of West Germany as a laggard at this time is mistaken; biased by authors

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[136] Hansard, 'Cigarette Smoking and Health Warnings', Written answers, 316 (16 March, 1971), cc. 432-4WA.
[137] Berridge, 'Science and Policy', p. 155.
[138] Deutscher Bundestag, Drucksacke, 7/2070 (10 May, 1974), p. 10.
[139] Brandt, *The Cigarette Century*, p. 444.
[140] It is important to recognise that this 'freedom' is socially-constructed. As noted in the introduction, the perspective of 'actually existing neoliberalism' draws attention to the social construction of perceived-as-free markets; created and reproduced by the state and society through institutions such as private property rights and the legal system, and ideologies of individual rationality and market equilibration.
[141] Berridge, *Marketing Health*, pp. 178-9.

seeking to explain Germany's much more recent reputation, since the 1990s, as a 'major European tobacco control laggard' and 'reluctant partner' in the WHO's Framework Convention on Tobacco Control negotiations.[142] The differences between British and West German policy-makers' attitudes to advertising, and to scientific research, reflecting different structural and ideological conditions, continued to shaped their developing conceptions of the health risks associated with alcohol and tobacco, and other policy responses such as health education.

[142] Paul Cairney, Donley T. Studlar, and Hadii M. Mamudu, *Global Tobacco Control*: *Power, Policy, Governance and Transfer* (Basingstoke: Palgrave Macmillan, 2012), p. 209.

Chapter 2

Health education and the behavioural turn

Alongside voluntary agreements with industry, both the British and West German governments acted to control tobacco health risks by supporting health education campaigns from the early 1960s. Into the 1970s, such campaigns also addressed alcohol health risks, as the qualification of the 'disease' model of alcoholism by psycho-social analyses drew a connection between youth substance abuse and addiction in adulthood, and alcohol policy was positioned more toward the 'management' of predispositions and problems.[143] This chapter describes the changing strategies of health education in both Britain and West Germany through the lens of the 'behavioural turn', a term which describes the shift in both the scientific methods and policy goals of public health since the 1960s. The 'behavioural turn' describes both an increasing emphasis on individual behaviours as risk factors, and analysis of psychological reasons for risk-taking, as well as policy strategies promoting risk-averse behaviour and individual responsibility for health. [144] Behaviourism has been associated with the 'new public health', described in Foucauldian terms as governing individual decision-making by making calculating, risk-averse behaviour a condition for responsible citizenship.[145] The contradiction of the new public health is that the 'privatisation' of responsibility for health risk management purports to enable citizens to become 'experts of themselves' (governing their own behaviour in accordance with internalised expert knowledge), but risky and risk-averse behaviours are defined as public, not individual, knowledge. Viewed as a component of neoliberal governance, the 'freedom' of the individual (to self-manage) is contingent on the fulfilment of responsible behaviours defined by the state.[146] In other words, 'responsibility' is constituted by acting in prescribed ways; by relinquishing responsibility.

In historical perspective, the 'new public health' in Britain has ideological roots in the individualism of the then-'new' personal preventive health of the early twentieth century; and contemporary risk-factor analysis has matured from the epidemiological techniques developed to inform nineteenth-century public health, applied to chronic diseases.[147] The 'new' individualist public health is not even, as Berridge has observed, entirely in conflict with

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[143] Thom, *Dealing with Drink*, p. 7.
[144] Allen M. Brandt, 'Behaviour, disease, and health in the twentieth-century United States: The moral valence of individual risk', in Allen M. Brandt and Paul Rozin, *Morality and Health: Interdisciplinary Perspectives* (London: Routledge, 1997), p. 60.
[145] Peterson and Lupton, *The New Public Health*.
[146] Rose, 'Governing "advanced" liberal democracies', p.59.
[147] Peterson and Lupton, pp. 28-33.

environmentalist ideologies; behaviourist discourses have incorporated environmental reasoning, for example, about the 'pollution of public space' in light of the recognition of health risks associated with passive smoking.[148] Recognising these continuities, and the cumbersome temporality of 'newness', this author prefers the 'behavioural turn' as a descriptive term. It also captures the growing influence of psychological science upon public health discourses, echoing concurrent developments in behavioural and health economics, as well as emphasising the dynamism (the *turn*) fundamental to the perspective of 'actually existing neoliberalism' described in the introduction.

Tobacco control strategies have been depicted by a number of authors as emblematic of the behavioural turn in public health.[149] In the American context, Allen Brandt has emphasised public acceptance of the causal link between smoking and lung cancer as essential in legitimating statistical inference and risk-factor epidemiology as scientific justification for government intervention.[150] Berridge has described the role of the smoking-lung cancer link in legitimating statistical techniques in the British case, as well as driving the discursive shift toward individual responsibility and risk-based conceptions of health.[151] Berridge identifies the 'new health education' around smoking, using the techniques of mass media, as a novel feature of public health in Britain during the 1960s and 1970s, which, she argues, influenced later public health campaigns in other 'single issue' areas, including alcoholism.[152] Rosemary Elliot has demonstrated that tobacco health education campaigns were used in West Germany from the early 1960s to inform school children about the risks of taking up smoking.[153] Elliot argues that education campaigns throughout the 1960s and 1970s, along with efforts to curtail advertising directed at youths through voluntary agreements with industry, represented a neoliberal policy response designed to teach young people to 'negotiate' their own health decisions without directly interfering in the market.[154] This chapter presents new evidence on the earliest of these campaigns to inform a new interpretation of the changing aims of health education over time. The chapter focuses on the use of school-based primary education

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[148] Berridge, *Marketing Health*, p. 220.
[149] Berridge, *Marketing Health*, p. 16*;* Brandt, *The Cigarette Century*, pp. 211-2; Michael Mair, 'Deconstructing Behavioural Classifications: Tobacco Control, "Professional Vision" and the Tobacco User as a Site of Governmental Intervention', in Kristen Bell, Darlene McNaughton and Amy Salmon (eds.), *Alcohol, Tobacco and Obesity: Morality, Mortality and the New Public Health* (London: Routledge, 2011), p. 20.
[150] Allen M. Brandt, 'The Cigarette, Risk, and American Culture', *Daedelus*, 119: 4 (1990), pp. 161-5.
[151] Berridge, *Marketing Health*.
[152] Berridge, *Marketing Health*, pp. 164; 194.
[153] Rosemary Elliot, 'From Youth Protection to Individual Responsibility: Addressing Smoking among Young People in Post-war West Germany', *Medizinhistorisches Journal*, 45 (2010), pp. 66–101.
[154] Elliot, 'Inhaling Democracy', p. 5.

campaigns to combat both tobacco and alcohol health risks; a policy tool overlooked in much of the literature in favour of an emphasis on strategies such as advertising control, sales restrictions, and punitive taxation – strategies pursued in the United States and Britain.

The relationships of each government with scientists and industry, as well as the broader political structures and ideologies discussed in the previous chapter, shaped policy-makers attitudes to the role of government in health education, and the changing techniques, targets, and aims of health education between the early 1960s and late 1970s. While West German health education strategies drew on the decentralised network of school and community-based educational institutions administered by the *Länder*, remaining targeted almost exclusively at children and youth, the British Health Education Council (HEC) pursued a more centralised campaign directed at the whole population of smokers. This chapter frames developments in health education in both nations as different manifestations of a common behavioural turn, representative of different actual experiences of neoliberalisation. By the beginning of the 1980s, health education in both Britain and West Germany reflected not the neoliberal ideal of informing decisions by free and responsible individuals, but the discursive construction of a 'responsible citizen' pursuing risk-averse behaviour.

Early tobacco health education

Throughout the 1960s, policy-makers in Britain and West Germany negotiated the endorsement or acceptance of new scientific knowledge about the health risks of tobacco smoking in different ways. West Germany pursued health education campaigns targeted at youth and children, but distanced their messages from government, while in Britain health education was largely left to local authorities before the creation of the HEC in 1968, and care was taken to ensure that the government's clear stance navigated public and scientific opinion.

Contrary to the dominant depiction of Germany as particularly laggard in acting upon the health risks of tobacco smoking, the federal government of West Germany was directly involved in expansive health education campaigns as early as 1962.[155] At the time, the health risks of cigarette smoking had gone virtually un-mentioned in the *Bundestag* since the mid-1950s, when the parliamentary health policy committee was accused by a CDU member of being 'completely sterile' in its response to 'one of the most important' current public health issues.[156] Prior to the creation of the Federal Ministry of Health (BMG) in 1961, the Federal Health

[155] Elliot, 'From Youth Protection to Individual Responsibility'.
[156] Deutscher Bundestag, Plenarprotokolle, 1/259 (15 April, 1953), p. 12583.

Agency was the chief body responsibly for defining public health risks in West Germany, but the role of disseminating health information to schools and local authorities was taken up by the German Health Museum (DGM), based in Köln. In July 1962, the Information Service for Youth Protection (AfJ), a regional organisation based in Hessen set up by the DGM in 1954, brought together DGM director, Professor W. Fritsche, with the medical director of the BMG, Elizabeth Schwarzhaupt, as well as *Länder* ministers for work, welfare and health care, and education and culture, for the states of Weisbaden and Hessen respectively, to design a school education campaign and 'health competition' (*Gesundheitswettbewurb*) to educate students about the health effects of tobacco smoking.[157] The project was inspired by a competition run in the illustrated youth magazine '*Gib Acht!*' in 1961, the success of which had been used by the AfJ to lobby Schwarzhaupt to deliver funds for the 1962 program. The editor of *Gib Acht!*, Herr Hasenclever, was significantly involved in the planning process and design of the competition, which took the form of a questionnaire.

The emphasis in meetings, and in further correspondence between Fritsche, Hasenclever, and AfJ director, Herr Denzer, was on smoking as being particularly harmful to youth on account of the observed trend toward regular smoking from a younger age, and the connection between length of time as a smoker and the risk of developing lung cancer, evidenced in the British RCP's report of that year.[158] The emphasis on youth education was thus founded on a conception of the health risks of tobacco as particularly relevant to children, which was expressed in discussions in the *Bundestag* from 1964.[159] The youth focus also reflected a precedent of youth-targeted health education in Germany, dating to the First World War.[160] The 1962 competition, entitled '*Wer hat Recht?*' ('Who is right?') tested children with a series of questions about the chemical make-up of tobacco smoke, and the impact of smoking upon different bodily organs, and presented three extended scenarios in which one child explained the dangers of smoking to another who was being tempted to smoke. [161] The scenarios were located at sports events and parks, and suggested that the choice to smoke was an ill-informed, even childish one. Peer disapproval and embarrassment were featured in all three scenarios, alongside scientific information about the contents and harms of cigarette smoke.

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[157] Bundesarchiv, Bundesgesundheitsamt, B310/302, 'Sitzung der Gesundheitsausschusses des Aufklärungsdienst für Jugendschutz', 25 July 1962.
[158] Bundesarchiv, Bundesgesundheitsamt, B310/302, correspondence between Fritsche, Hasenclever, and Denzer, 31 August to 7 September 1962.
[159] Deutscher Bundestag, Plenarprotokolle, 4/109 (24 January, 1964), pp. 5027-9.
[160] Elliot, 'From Youth Protection to Individual Responsibility', p. 72.
[161] Bundesarchiv, Bundesgesundheitsamt, B310/302, 'Wer hat Recht?' text, attachment to letter from Denzer to Fritsche, 7 September 1962.

The scale of the *Wer hat Recht?* program was significant. The competition was run among one million children between eleven and sixteen; 200 000 via the magazine 'Gib Acht!' and 800 000 throughout 8000 schools across the country. Of the magazine submissions, solicited from children having not completed the education program, 57% of answers were correct, while the average score for schools submissions was 75.9%. By this measure, Fritsche judged the program a success.[162] The results of the competition were published in June 1963, in a brochure, '*Zum Problem des Rauchens: Eine Zusammenfassende Darstellung fur die Lehrerschaft*' ('On the problem of smoking: A summary for teachers'), of which the BMG funded 300 000 initial copies, distributed via the DGM to 223 individuals, organisations, and publications, including major newspapers *Die Zeit*, *Die Welt*, and *Der Spiegel*, and via the AFJ to schools nationwide. An additional batch of one million copies was ordered by the BMG in 1964. The structure of the campaign, combining a schools education program with youth press publications and a follow-up pamphlet, became the model for the *Neue Trend – No Smoking Please* campaigns, described by Elliot as central to the work of the newly-created Federal Centre for Health Education (BZgA) from 1967 onwards, under Fritsche's directorship.[163] The form of the *Wer hat Recht?* program, with role-plays drawing upon peer group pressure, asking students to choose between smoking and familiar leisure activities, was emulated in further campaigns into the 1970s.[164] Speaking at the Second World Conference on Smoking and Health in 1972, Fritsche noted that the aim of the *Neue Trend* campaigns was to inform young people about smoking on their own terms; to 'use the channels that teenagers use themselves'.[165] Elliot has argued that this motivation was also reflected in the use of English language, which, based on psychological research into the factors shaping youth behaviour, was designed to connect with the popularity of international youth culture, and to distance the campaign from government.[166]

Efforts to distance health education from government can already be observed in the early 1960s, reflecting a desire by policy-makers to avoid committing to a particular stance on smoking while the scientific basis of its health risks was still conceived of as incomplete. *Zum Problem des Rauchens* had presented the available evidence, noting that higher levels of consumption were associated with higher risk of disease, but that where 'un-damaging consumption' might end, and 'self-destruction' begin had not yet become clear; that cigarette

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[162] Bundesarchiv, Bundesgesundheitsamt, B310/302, memo signed by Fritsche, 1964.
[163] Elliot, 'Inhaling Democracy', p. 14.
[164] Elliot, 'Inhaling Democracy', pp. 16-17; Bundesarchiv, Bundesgesundheitsamt, B310/506, 'Gesundheitserziehung und Schule Curriculum: Alkohol, Selbstmedikation, Werbung und Gesundheit, Rauchen und Gesundheit', 1974.
[165] Robert G. Richardson (ed.), *Proceedings of the Second World Conference on Smoking and Health* (London: Pitman, 1972), p. 79.
[166] Elliot, 'Inhaling democracy', p. 15.

smoke had been found to contain a number of carcinogens, but in trace amounts.[167] This tone was clinical, rather than instructive. When questioned in the *Bundestag* in January 1964, a parliamentary secretary to the BMG assured a Free Democratic Party member concerned that the brochure and an upcoming newsreel would represent 'an expression of government opinion', that the educational material presented only 'the science'.[168] While the Ministry purported to represent 'the science', the interpretation of health risks presented was affected by existing official and social attitudes. The use of images in *Zum Problem des Rauchens* which connected tobacco smoking with alcohol abuse reflected their long-running dual association as *Genussmittel*, and the first page of the brochure even featured a German folk poem in praise of tobacco from 1720.[169] The use of chemical symbols and scientific language to represent carcinogenic substances in tobacco smoke, however, conveyed a sense of scientific legitimacy.[170] The strategy of *appearing* to present an objective view allowed the BMG to support health education about smoking without committing the government to a clearly anti-smoking agenda. That the government was not so closely linked with scientific researchers as in Britain, may have enabled this distance.

In Britain, the causal connection between smoking and lung cancer asserted by the 1962 RCP report had already been endorsed by the MRC and a cabinet committee on lung cancer in 1957.[171] Uncertainty remained about the government's role in publicising this link in light of incomplete scientific evidence about the chemical contents of tobacco smoke and their biological effect, but children were identified as particularly affected as they were considered more vulnerable to advertising than the adult 'thoughtful citizen'.[172] In 1958-9, 90% of local health authorities agreed that 'special attention' should be given to the education of children and youth, in light of 'considerable public apathy' about the health risks of tobacco smoke.[173] According to the government, anti-smoking advertisements using posters, pamphlets, and local press were combined with community talks, with an emphasis on protecting children, in most areas by 1961.[174] Berridge has asserted that local efforts may have been less consistent than the

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[167] Bundesarchiv, Bundesgesundheitsamt, B310/302, 'Zum Problem des Rauchens: Eine Zusammenfassende Darstellung fur die Lehrerschaft', 1963.
[168] Deutscher Bundestag, Plenarprotokolle, 4/109 (24 January, 1964), pp. 5027-9.
[169] Elliot, 'From Youth Protection to Individual Responsibility', p. 91.
[170] Bundesarchiv, Bundesgesundheitsamt, B310/302, 'Zum Problem des Rauchens', 1963.
[171] Berridge, *Marketing Health*, p. 44.
[172] Hansard, 'Smoking and health', Parliamentary debates, 635 (22 March, 1962), c. 635; 'Lung Cancer', Parliamentary debates, 737 (9 December, 1966), cc. 1780-1.
[173]Hansard, 'Smoking (Children)' Parliamentary debates, 605 (7 May, 1959), cc. 719-20.
[174]Hansard, 'Smoking and Tobacco Advertising', Parliamentary debates, 646 (18 October, 1961), cc. 326-7.

government suggested, varying according to the personality of the Medical Officer of Health.[175] The central government encouraged regional support for local efforts, but were not engaged in funding or directing the content of campaigns.[176] A fuller examination of local sources could indicate the extent and character of local public health action at this time, but anti-tobacco health education in schools had been ruled out by the central government in 1958.[177]

The question of why centrally-organised school-based education campaigns were not pursued in Britain at this time has been left unaddressed by existing literature. Berridge blithely remarks that perhaps the heavy-smoking Director of Education, or 'clouds of cigarette smoke' in which local committees discussed tobacco policy, had some effect.[178] We know that children and young people *were* identified as particular targets for health education, both in parliament and among local health authorities, as well as among the regional divisions of the British Medical Association (BMA), who, while outside the policy-making apparatus, influenced official conceptions of health risks and policy strategies. In 1960-61, the BMA ran a 'subject of the year' inquiry themed 'Health Education', which gathered responses from its local divisions. Less than a third mentioned smoking as a key area of interest, but those which did were concerned that media campaigns or anti-smoking 'propaganda' would create 'more human suffering' by instilling an 'unhealthy fear' of cancer in the masses, favouring school- and youth club-based education instead.[179] The Central Council for Health Education (CCHE)[180] had run a nationwide 'van campaign' in 1962-3 which was well received in schools and youth clubs.[181] However, the 1964 'Cohen report' by the CCHE in committee with the corresponding body for Scotland, emphasised mass media rather than schools-based campaigns, noting the 'failure to find a place for systemic health education in the curricula' and 'the general lack of organised and methodical health education in schools'.[182]

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[175] Berridge, *Marketing Health*, p. 71.
[176] National Archives, Department of Education and Science, ED 121/656, 'Pamphlet No. 31: Suggestions on Health Education', 1962.
[177] National Archives, Ministry of Health, MH 55/2225, circular 17/58, 1958.
[178] Berridge, *Marketing Health*, p. 71.
[179] Wellcome Library, Sir (William) Allen Daley papers, PP/AWD/H/8/1, British Medical Association – 'Health Education', 1960-1.
[180]Inaugurated in 1927, and made responsible for some local activities under the NHS; composed primarily of local and regional councillors, doctors, and public health professionals, as well as some central government representatives.
[181] Berridge, *Marketing Health*, p. 72.
[182] Ministry of Health, the Central Health Services Council, and the Scottish Health Services Council, *Health Education: Report of a Joint Committee of the Central and Scottish Health Services Councils* (London: HMSO, 1964), p. 73.

One explanation for the lack of nation-wide school health education programs might therefore be a lack of institutional capacity. The *Wer hat Recht?* campaign was enabled in West Germany by cooperation between the newly-created BMG and organisations like the DGM, AfJ and BZgA, which used existing networks of communication with the *Länder* ministers for culture, who were responsible for both health, and education in schools. No such coordination existed between the Departments for Health and Social Services and for Education in Britain, and while the CCHE connected local health authorities and voluntary organisations as 'educator to the educators', its national influenced was circumscribed and it was not directly networked with the schools.[183] It was not until 1975 that nation-wide school-based tobacco health education campaigns emerged.[184] The previous year's NHS restructuring had given the HEC, created from the Cohen committee in 1968, greater responsibility for coordinating health education at a national level through collaboration with Area Health Authorities and local and regional education services.[185] These changes, designed to cut costs and streamline services, were likely influenced by neoliberal ideologies of frugal governance, but they may also have enabled the kinds of instructive health education campaigns central to behaviourist public health strategies. Ideological and structural changes associated with neoliberalism did not, therefore, follow straightforwardly from one to the other. The frame of 'actually existing neoliberalism' draws our attention to the evident complexity of neoliberalisation in practice.

The aims and targets of health education

By the mid-1970s, tobacco health education in both Britain and West Germany aimed to enact behavioural change at a population level. While in Britain the DHSS supported strategies of mass media counter-marketing targeted at the whole population, in West Germany health education remained targeted at children and youth, despite a stated aim to 'awaken reason' against smoking at a population level. The transition from the mid-1960s to late-1970s represents a common behavioural turn, but still reflects different strategies for the legitimation of knowledge about health risks in the different contexts. A comparison of concurrent strategies on alcohol health education serves to highlight the differences.

Despite a relative lack of health education in British schools, a Ministry of Health poster campaign of June 1962 was arguably directed at youth. A series of posters featuring images of

[183] Wellcome Library, Sir (William) Allen Daley papers, PP/AWD/H/3/7, Central Council for Health Education, 'Papers concerning submission of evidence to the Joint Committee on Health Education appointed by the Central and Scottish Health Services Councils'.
[184] Hansard, 'Smoking and Health', Parliamentary debates, 903 (16 January, 1976), c. 793.
[185] Wellcome Library, The Institute of Health Education archives, SA/IHE/D/1/2, 'NHS Reorganisation Circular HRC (74) 27', March 1974, pp. 1-2.

adolescents urged the reader, 'Before you smoke, THINK, cigarettes cause lung cancer'.[186] In November, the posters were banned by the joint censorship committee of the poster advertising industry for 'undue exaggeration'; the committee preferring the phrase 'may cause lung cancer', reflecting lingering uncertainty about endorsing the causal link even after publication of the RCP's report.[187] While some officials suggested that the move was 'clearly financial' in motivation, the government withdrew the series and instead ran a text-only poster reading, 'Danger! The more cigarettes you smoke, the greater the risk of death from lung cancer, chronic bronchitis, or heart disease. You have been warned'. When the 'cigarettes cause lung cancer' posters were re-released in 1964, the version featuring a boy in school uniform, shrouded in darkness but for the lighter sparking his cigarette, was replaced by an image of a young woman, accepting a cigarette from an unseen stranger.[188] [189]

The use of poster campaigns, or 'counter-advertising' as a health educational tool by the central government in Britain reflected the conception of advertising as a form of market information, central to the discourses of informed choice around the 'harm reduction' strategies described in the previous chapter. The period of 'harm reduction' from the late-1960s also saw smokers 'who cannot stop altogether' become particular targets for health education designed to 'steer' them 'toward less dangerous ways of smoking'.[190] This justified the use of warnings on packets, which had previously been dismissed as ineffective, following their negligible impact in the first year of use in America.[191] Without this discourse of harm reduction, the dependent smoker was not a particular target of health education in West Germany in the 1960s and 1970s. The use of poster campaigns in Britain also represented a shift in the techniques of health education toward more centralised campaigns employing the mass media techniques promoted by the Cohen report.[192] While central government closeness to industry and medical scientists may have limited its willingness to take a clear stance on the health risks of tobacco at the beginning of the decade, by the late 1960s this closeness and negotiational strength enabled mass media campaigns to compete with industry advertising, complemented by voluntary agreements. From

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[186] National Archives, Central Office of Information, INF 13/254, 1962-7.
[187] Hansard, 'Poster advertising on dangers of smoking', Parliamentary debates, 248 (4 April, 1963), cc. 645-53.
[188] National Archives, Central Office of Information, INF 13/254; 1962-7.
[189] Berridge and Elliot have elsewhere documented the role of female smoking, and women as targets for anti-smoking information in Britain. This chapter has focussed primarily on children as targets, and space constrains a full exploration of women here as well. On women, see: Virginia Berridge, 'Constructing Women and Smoking as a Public Health Problem in Britain, 1950s-1990s', *Gender and History*, 13:2 (2001), pp. 328-48; Rosemary Elliot, *Women and Smoking Since 1980* (London: Routledge, 2007).
[190] Hansard, 'Cigarettes (Tar and Nicotine Yields)', Written answers, 842 (8 August, 1972), cc. 326-8W.
[191] Hansard, 'Cigarettes (Prohibition of Advertising)', Parliamentary debates, 829 (19 January, 1972), c. 487.
[192] Berridge, *Marketing Health*, p. 74.

1971, the HEC ran television campaigns, 'to bring the risks involved in cigarette smoking to families in their homes'.[193] In West Germany, limited regional efforts to use counter-advertising on television and in newspapers were thwarted when publishers and broadcasters viewed such (unpaid) advertisements as a threat to their income from lucrative tobacco industry advertising deals.[194] This interplay between the structural constraints on policy, and the ideas about consumption, risk, and information which underpinned policies is shaped the different experiences of the behavioural turn in Britain and West Germany.

While official tobacco health education in Britain was shifting to a mass audience from the mid-to-late-1960s, education around alcohol health risks remained predominantly confined to the general practitioner's surgery, and largely at the initiative of non-governmental organisations. The new media tools of official public health strategies, however, were also reflected in voluntary action at the time. In December 1963, for example, the Rowntree Trust's steering group on alcoholism funded a 22-minute documentary film on the signs and symptoms of alcoholism, targeted at GPs and an 'educated audience' of health care professionals, explicitly discussing the use of 'modern' media.[195] Conceptions of the broader risks of alcohol consumption, and the idea of alcoholism as a progressive disease, began to emerge among policy-makers from the mid-1960s into the 1970s, responding – as noted in chapter one and the introduction – to rising levels of consumption, increasing connections with non-governmental public health lobbies, and ideas from psychological science which depicted alcoholism as not only a 'disease' of the mind, but a condition to which individuals became predisposed through stress and other psycho-social factors.[196] In 1973, the DHSS provided local health authorities with advice on reducing the stigma associated with alcoholism, to encourage individuals to seek help while their alcohol abuse was still a 'social problem', and before it became a 'medical disease'.[197] At the same time, central funding of treatment and psychological research began to expand, with the purpose of gathering 'more reliable information' about alcohol abuse.[198]

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[193] Hansard, 'Cigarette Smoking and Health Warnings', Written answers, 316 (16 March, 1971), cc. 432-4WA.
[194] Elliot, 'From Youth Protection to Individual Responsibility', p. 93.
[195] Wellcome Library, Sir (William) Allen Daley papers, PP/AWD/H/6/33, Joseph Rowntree Trust Steering Group on Alcoholism, Minutes of a meeting, 23 October 1963.
[196] Hansard, 'Alcoholism', Parliamentary debates, 270 (2 February, 1965), cc. 1401-8; 'Mental Hospital Patients', Parliamentary debates, 787 (16 July, 1969), cc. 601-2; 'Alcoholism', Parliamentary debates, 843 (25 October, 1972), cc. 1180-1.
[197] Hansard, 'Alcoholism', Parliamentary debates, 358 (19 March, 1975), cc. 782-3.
[198] Hansard, 'Alcoholism', Written answers, 890 (22 April, 1975), c. 288W.

In 1976, nation-wide school-based education campaigns about the health risks of alcohol consumption commenced, alongside the programs on the subject of tobacco smoking.[199] Alcoholism and the broader health risks of alcohol, remained, however, contested concepts in official circles. The uncertainty of some policy-makers was expressed by Lord Hunt, who remarked in March 1975 that 'every alcoholic has an individual problem, everything to do with alcoholics is equivocal and it is dangerous to generalise'.[200] The health risks of alcohol were considered 'negligible' compared with those of smoking tobacco by some, and far worse by others.[201] Why, then, was alcohol health education initiated while there remained so much uncertainty about its potential health risks, when in the case of tobacco establishing the scientific legitimacy of the lung cancer link had been a primary concern? Here, the comparison with West Germany is instructive.

Alcohol health education in schools appeared in West Germany from about the same time as in Britain. The Social Democratic Party (SPD) government had recently come under increasing pressure from the CDU opposition, who blamed the SPD's progressive family policies for the destruction of youth and increasing rates of youth alcohol, tobacco, and illegal drug abuse.[202] The government suggested that more research was needed into 'the foundations of alcoholism', but from 1974 it launched national school-based health education campaigns to educate youth about the risks of over-consumption, especially from a young age.[203] A brochure, 'Alcohol and Nicotine are also Drugs', and primary-level curriculum, 'Alcohol, Smoking, Self-medication, and Health', were produced by the BZgA, and disseminated to schools through the established network operating through the *Länder* ministers for culture.[204] In West Germany, as in Britain, the health risks of alcohol consumption had been primarily conceived of in terms of the incidence of alcoholism, until alcohol abuse became associated with other forms of stress in the 1970s.[205] The CDU's political critique of an apparently destructive family policy appealed to a bourgeoning discourse about childhood stress, alcohol abuse by youth, and its association with alcoholism and addiction in later life, which responded to the international influence of psychological perspectives on alcoholism.[206] Childhood stress was one factor affecting alcoholism, which was still – ultimately – a problem of adults, but health education remained targeted at children. Why?

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[199] Hansard, 'Smoking and Health', Parliamentary debates, 903 (16 January, 1976), c. 793.
[200] Hansard, 'Alcoholism', Parliamentary debates, 358 (19 March, 1975), c. 787.
[201] Hansard, 'Smoking and Health', Parliamentary debates, 903 (16 January, 1976), c. 825.
[202] Deutscher Bundestag, Plenarprotokolle, 8/56 (11 November, 1977), pp. 4317-9.
[203] Deutscher Bundestag, Plenarprotokolle, 7/108, (18 June, 1974), pp. 7320-2.
[204] Deutscher Bundestag, Plenarprotokolle, 8/210, (16 April, 1980) p. 16848.
[205] Deutscher Bundestag, Plenarprotokolle, 8/56 (11 November, 1977), pp. 4317-4.
[206] Valverde, *Diseases of the Will*, p. 103.

Firstly, an existing network of school-based health education existed, to which alcohol education could easily be added. Secondly, although ideas about the broader health risks of alcohol consumption had been a concern of organisations like the DHS, the existing framework of evidence for defining a broader risk group was too pliable to legitimate any claims, with ideas about 'reasonable consumption' debated as being between 80 and 160 grams (10 to 20 units) per day.[207] The lack of precision and level of this range was comparable with ideas in other nations at the time. In Britain, recommended consumption units were not endorsed by the government until 1986, after first being suggested in the Royal College of Psychiatrists' 1979 report, *Alcohol and Alcoholism,* as somewhere between 10 and 20 units per day.[208] The impact of recommended consumption limits on anti-alcohol policy-making will be explored more fully in the following chapter. In 1977, West German Minister for Health, Antje Huber, had expressed an interest in the proportion of the population for whom excessive alcohol consumption was not the product of a biological predisposition or childhood stress, but rather psycho-social dependence forged by an indulgent consumer lifestyle.[209] These concerns mirror connections that had already made in the alcohol research by Jellinek of 1954.[210] Such ideas, however, derogated a consumer culture emblematic of West Germany's postwar 'economic miracle', which was already suffering from the mid-1970s slump; and at the time, they also remained un-measurable while a 'reasonable' level of consumption was not clearly defined. Youth education campaigns to, at the very least, prevent childhood consumption associated with abuse and addiction in adulthood, were agreeable, even if not designed to reduce consumption in the overall population.[211] The cultural emphasis on protection of children and family, and timely challenges to family policy by the CDU, further supported the move.

The two factors identified, of institutional capacity for action, and measurability of risk-group claims, also hold in the British case. School-based alcohol health education joined tobacco in informing the members of society perceived as most vulnerable. The transformation of alcohol abuse into 'a problem of the many' was only enabled by the later endorsement of much lower 'recommended units' by the Royal Colleges in 1986 and 1987, making drinking a 'whole population' issue, a concept which Nicholls has described as an essential shift in fashioning

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[207] Deutscher Bundestag, Plenarprotokolle, 8/56 (11 November, 1977), p. 4320.
[208] Royal College of Psychiatrists, *Alcohol and Alcoholism: The report of a Special Committee on Alcoholism of the Royal College of Psychiatrists* (London: Tavistock, 1979), pp. 79, 86.
[209] Deutscher Bundestag, Plenarprotokolle, 8/56 (11 November, 1977), p. 4320.
[210] Room, 'The World Health Organisation and Alcohol Control', p. 86.
[211] Further research could confirm or complicate this interpretation when Bundesarchiv folders detailing alcohol education programs throughout the second half of the twentieth century, up to 1991, are opened.

risk-taking behaviour as a 'species of freeloading' in the British imagination.[212] Such a sentiment was already reflected in relation to smoking in 1972, tobacco health risks described as a 'community issue' due to the impact of the individual smoker's behaviour on the family, and the cost to the NHS.[213]

Whole-population conceptions of the health risks of tobacco and alcohol were more problematic in West Germany. Elliot has identified that the economic liberalism of the *Soziale Marktwirtschaft* prevented the kind of hostility to industry which underpinned the advertising control and taxation strategies used from the 1970s in the UK.[214] It is important to note that the ideologically 'liberal' market was still constructed by the state through legislation like the Law against Restraints on Competition – a fact which Elliot fails to directly convey. Moreover, the perception of individuals engaging in risky behaviours as infringing upon the rights of others, which began to grow in Britain, was not as relevant in the West German context. The West German welfare state was built on the principle of solidarity through universal security, not dependent upon behaviour, or notions of desert such as those which prevailed in more residual welfare states like Britain.[215] The *Solidaritätsprinzip* (solidarity principle) features throughout the period in discussions on the right of smokers to choose to smoke, but is particularly prevalent during the 1970s, as ideas about passive smoking begin to challenge prevailing rights frameworks. [216] The impact of passive smoking discourses in both countries will be addressed in the following chapter.

By 1975, the stated aim of tobacco health education in West Germany was 'to make the population aware that any kind of smoking is injurious to health', with 'individual responsibility' and behavioural changes 'at the heart of the problem' of smoking-related disease prevention.[217] The Federal Ministry for Youth, Family, and Health (BMJFG)[218] wrote that 'Health education aims to achieve a change in behaviour'.[219] From the mid-1970s and into the 1980s the government maintained, however, that it would not ban smoking for 'mature' adults,

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[212] Nicholls, *The Politics of Alcohol*, pp. 212-4, 251.
[213] Hansard, 'Cigarettes (Prohibition of Advertising)', Parliamentary debates, 829 (19 January, 1972), cc.486-94.
[214] Elliot, 'Inhaling Democracy'.
[215] Esping-Andersen, *The Three Worlds of Welfare Capitalism*, pp. 126-7.
[216] Deutscher Bundestag, Plenarprotokolle, 7/176 (5 June, 1975), p. 12324; Plenarprotokolle, 6/105 (5 March, 1971), pp. 6130-1; Plenarprotokolle, 7/216 (23 January, 1976), p. 14987.
[217] Deutscher Bundestag, Plenarprotokolle, 7/176 (5 June, 1975), pp. 12315-20; Plenarprotokolle, 7/204 (28 November, 1975), pp. 14190-1.
[218] The BMJFG consolidated the Ministry for Family and Youth, and Ministry for Health (BMG) in 1969.
[219] Deutscher Bundestag, Drucksacke, 7/3597 (28 April, 1975), p. 10.

or 'spoon-feed responsible citizens'.[220] Most depictions of tobacco regulation in West Germany contend, directly or by implication, that this stated aim was not genuine; that the government did not actually intend to achieve a change in behaviour. This is the interpretation of the contemporary political opposition, who accused the government of relying on funds from tobacco taxation, as well as that of historians who have depicted West Germany as laggard on tobacco regulation.[221] It must also be Elliot's interpretation, given that she suggests the government aimed not to change behaviours, but simply to provide citizens with information to navigate their own decision-making process, in line with neoliberal ideals. Elliot draws attention to the statement by the BMJFG, in 1974, that its goal was 'not to force healthy behaviour *by laws or pressure*, [but] to awaken reason and criticism' (emphasis added).[222] The *Bundestag* did not legislate to ban or restrict tobacco products, or to increase their price, but the character of health education targeted at children in the 1970s constructed an idea of 'responsibility' that strongly promoted the value of non-smoking.

It is Elliot's evidence on health education in the 1970s, in light of the new detail above from a reassessment of earlier campaigns, which most convincingly suggests that the BMJFG's stated aims were in fact their actual goals; that health education campaigns targeted at children were designed to promote a behavioural change. The techniques designed to undermine the association between smoking and 'manhood' used in the 1970s *Neue Trend* campaigns, and to promote the virtues of non-smoking, and a critical response to tobacco advertising, were based upon psychological research into the motivations of youth behaviour.[223] Unlike the earlier *Wer hat Recht?* campaign, they did not focus on the health risks of smoking or the chemical constituents of tobacco smoke, but rather 'on patterns of behaviour and cultural understandings of smoking. The aim was to create positive values around non-smoking.'[224] These psychological techniques, designed to promote behavioural change by presenting a particular path as a desirable and sensible *choice*, are characteristic of the 'behavioural turn'. Elliot's interpretation of the West German health education strategy as a form of neoliberal governance holds, but it is crucial to distinguish here between the *ideals* of neoliberalism and the actually-existing practices of governments. The practice of leading individuals toward a particular, socially-desirable choice through conditioning of preferences has been described by behavioural

[220] Deutscher Bundestag, Drucksacke, 7/2070 (10 May, 1974), p. 11; Plenarprotokolle, 11/46 (3 December, 1987), p. 3163.
[221] Deutscher Bundestag, Plenarprotokolle, 7/216 (23 January, 1976), p. 15009; Plenarprotokolle, 10/32 (9 November, 1983), p. 2121; Grüning et al, 'Puffing Away?'; Cooper and Kurzer, 'Rauch ohne Feuer'.
[222] Elliot, 'Inhaling Democracy', p. 6, quoting Deutscher Bundestag, Drucksacke, 7/2070 (10 May, 1974).
[223] Elliot, 'Inhaling democracy', p. 14.
[224] Ibid, p. 15.

scientists as ‘nudge’. Famously popularised as a suggested tool for governments in the 2000s, ‘nudges are not mandates’, but they significantly alter the subject’s incentives to act and quite often become more effective that direct regulation of behaviour.[225] This evidence of early ‘nudge’ techniques in West German tobacco health education does not reflect any kind of policy divination on the part of the BMJFG, but rather an active process of neoliberalisation in practice. The promotion of healthy behaviour *could not* be achieved through more direct regulation, as a result of anti-cartel legislation and the privileging of individual self-determinacy, fundamentally assured by the political culture of the *Grundgesetz*; as well as EEC constraints on West German tax strategy (to be elaborated in the following chapter). The behavioural turn in health education adapted existing policy tools to the new strategy of health promotion within existing ideological and structural limits; but the aim of health education was to – indirectly – regulate individual behaviour.

[225] Richard Thaler and Cass Sunstein, *Nudge: Improving decisions about health, wealth, and happiness* (London: Yale University Press, 2008).

Chapter 3

International benchmarking and policy convergence

The previous chapters have discussed the definition of health risks and framing of policy responses in Britain and West Germany, arguing that that between the 1960s and late-1970s a common 'turn' toward more neoliberal policies was shaped in practice by distinct national political structures and ideologies. This chapter turns to the period since 1975, which has usually been identified as one of structural 'convergence' in health care system and welfare state types, sometimes characterised as an ideologically-driven 'retrenchment' of services; a reorganisation of bureaucracies perceived as 'unwieldy'.[226] West Germany's shift away from general taxation funding of hospitals between 1972 and 1977, and Britain's decentralisation of health care administration from 1974 and into the 1980s have been depicted as starting points in this process; responding to budgetary pressure as a result of rising welfare costs, and the impact of stagflation in the wake of the 1973 Oil Crisis.[227] A loss of confidence in Keynesian economic management strategies at this time contributed to the legitimation, and proliferation, of existing neoliberal ideas about the immoralities and inefficiencies of economic planning and social programmes. However, as proponents of 'actually existing neoliberalism' stress, the neoliberal 'privatisation' of services has been incomplete; combined with new regulations and different methods of intervention.[228] The 1974 creation of Area Health Authorities in Britain, for example, actually made local authorities *more* accountable to centrally-determined policy benchmarks, by empowering organisations like the HEC. This dissertation argues that the pursuit of alcohol and tobacco control policies purporting to confer individual responsibility for health risk management represent an extension of state intervention – framed in a different way.

In relation to alcohol and tobacco, this era can be described as one of convergence in conceptions of health risks, and in scientific justifications for policy action, as well as in policy toward the end of the period. Paulette Kurzer has argued that social policy convergence reconstructs national attitudes in an international framework of cultural meanings and policy tools, but that national officials can still reject 'mainstream' frameworks when international

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[226] Robert Haveman, Barbara Wolfe, and Victor Halberstadt, 'The European Welfare State in Transition', in J.L. Palmer (ed.), *Perspectives on the Reagan Years* (Washington, DC: Urban Institute Press, 1986), pp. 148, 154; Francis G. Castles, *The Future of the Welfare State: Crisis Myths and Crisis Realities* (Oxford: Oxford University Press, 2004), ch. 4.
[227] Rothgang et al, *The State and Health Care*, pp. 94, 175.
[228] Damien Cahill, 'The embedded neoliberal economy', in Damien Cahill, Lindy Edwards, and Frank Stilwell (eds), *Neoliberalism: Beyond the Free Market* (Cheltenham: Edward Elgar, 2012), pp. 113-4.

norms conflict with ways of thinking fundamental to national identity.[229] Internationalisation does not negate pre-existing structures and ideologies. The main international organisations influencing health and welfare policy, including tobacco and alcohol policy, in Britain and West Germany in this period are the World Health Organisation (WHO) and European Economic Community (EEC). While international organisations can influence policy directly, through recommendations or treaties, international professional 'best practice' also shapes national policy through networks of expert scientific advisors.[230] Betsy Thom has noted that the expansion of alcoholism treatment research into 'large, international bodies of studies' throughout the 1980s contributed to convergence in treatment techniques and evidence.[231] The internationalisation of scientific knowledge, through professional networks and organisations like the WHO, is a process associated with neoliberal globalisation, and while the extent to which regional organisations like the EEC represent globalising forces has been debated, their role in reducing barriers to trade has certainly contributed to the donning of the 'golden straightjackets'.[232] But while such processes purport to rationalise expert knowledge, the impact of international frameworks on national policy is significantly shaped by local structural and ideological conditions; internationalisation has not meant the *actual* rationalisation of policy-making across borders.

This chapter contends that both of these 'paths' shaping policy convergence – through international organisations, and through professional experts – have forged international 'benchmarks' by which national policy is legitimated. 'Benchmarking', like 'nudge' theory, is a management strategy which has experienced considerable hype in both the business and public policy worlds since the 2000s, following publication of a seminal business text.[233] It describes the process of setting measurable targets in terms of an external (usually industry) standard, about which local data can be collected and analysed to inform adaptation to the standard, and assessment of success. Benchmarking in public policy can be viewed in terms of Theodore Porter's conception of 'rational' policy legitimated through objective, expert knowledge. As Porter asserts, the legitimacy of claims is affected by the measurability of processes, and the trusted status of the expert (or, standard-setter).[234] This chapter therefore explores the changes in the ways in which alcohol and tobacco health risks were 'measured' in the period after 1975,

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[229] Paulette Kurzer, *Markets and Moral Regulation: Cultural Change in the European Union* (New York: Cambridge University Press, 2001), pp. 4, 170.
[230] David P. Dolowitz and David Marsh, 'Learning from abroad: The role of policy transfer in contemporary policy-making', *Governance*, 13:1 (2000), pp. 10-11.
[231] Thom, *Dealing with Drink*, p. 211.
[232] Thomas Friedman, *The Lexus and the Olive Tree,* revised edition (London: Harper Collins, 2000).
[233] Robert J. Boxwell, *Benchmarking for Competitive Advantage* (New York: McGraw-Hill, 1994).
[234] Porter, *Trust in Numbers*, ch. 5.

and the international networks of scientific exchange which shaped this process, as well as the influence of standards set by the increasingly legitimate WHO and EEC. Just as the health education strategies described as instances of 'nudge' in the previous chapter were not envisioned by policy-makers in these terms, use of the concept of 'benchmarking' does not imply, anachronistically, that policy-makers prior to the 1990s were consciously applying this management strategy; rather that their actions can be understood through this lens. Recent sociological work on benchmarking techniques in the French public sector has observed that, while envisioned as a practical strategy for improving efficiency, the practice of benchmarking has the effect of enhancing central control.[235] Benchmarks help to define policy knowledge as objective, and in the context of alcohol and tobacco contribute to the normative construction of risk-averse behaviour as responsible, rational, and constitutive of individual freedom.

Changing science and policy knowledge

The major shifts in definitions of tobacco and alcohol health risks in this period are the introduction of recommended alcohol units, and the dangers of 'passive smoking'. Both blur the direction of influence between scientific and policy knowledge. Richard Doll described the danger of passive smoking as 'a fact waiting to happen'; an epidemiologically insignificant health risk, but one which would further the interests of the anti-smoking lobby.[236] The thresholds for alcohol intake have also been described as lacking in virtually any medical scientific grounding.[237] These new conceptualisations, however, impacted the way that health risks associated with alcohol and tobacco, and policy responses to them, were measured – at a whole population level. The process of adapting whole-population risk into policy knowledge was manifested differently in Britain and in West Germany, but policy responses in both nations reflect international networks and processes of benchmarking.

The previous chapter suggested that in both Britain and West Germany, the pursuit of anti-alcohol health education in schools from the mid-1970s reflected a desire to protect children from the risk of developing alcohol dependence or drinking-related social problems in later life. While a broader interest in the social problems of drink was on the agenda in both countries by the mid-1970s, neither acted to curb alcohol consumption at a population level, with the exception of continued campaigns to combat drink-driving. In West Germany, the law imposed higher penalties upon drunk drivers who caused accidents than those who were simply driving

[235] Bruno and Didier, *Benchmarking*, ch. 3.
[236] Berridge, *Demons*, p. 181.
[237] Nicholls, *The Politics of Alcohol*, pp. 212-4; Thom, *Dealing with Drink*, p. 129.

over the limit, but the infrastructure for stopping suspect drivers was inconsistent between regions.[238] In Britain, breath testing of any driver suspected of being over 0.08 BAC had been introduced in 1967, but by 1988 the idea of random breath-testing, being used in Australia and Sweden, still proved extremely unpopular among policy-makers.[239] The moral problem posed by direct monitoring of behaviour by police was also a concern for alcohol licensing. Mariana Valverde depicts alcohol control in Britain as having been traditionally exercised through the government of place, rather than person.[240] However, more permissive licensing after 1945 weakened such regulations as a tool for influencing alcohol consumption.[241] By 1972, the Departmental Committee on Liquor Licensing, chaired by Lord Erroll, suggested that it was 'very far from establishing that licensing law [had] exercised or [was] likely to exercise a decisive influence' over consumption.[242] The Erroll Report recommended liberalising reform of licensing, but among its 100 recommendations, also made observations on regulations in practice in Sweden; including harsher sentencing for drunk drivers, and the rule that young persons carry proof of age. The latter was framed as a solution to the problem faced by publicans of identifying 15, 16, or 17-year-olds from 18-year-old patrons, given that the prospect of police visits to public houses had been wholeheartedly rejected by parliament.[243] There was some precedent of looking to Sweden for leadership on alcohol policy, with the MRC research into breath measurement devices from 1956 having taken inspiration from the already-operating Swedish breath-testing system.[244]

There was comparatively little intervention in the spaces of alcohol consumption by the West German federal government, with licensing decentralised to the *Länder* and substantially self-regulated by local communities. From the 1980s, however, some central regulations came into place. Changes to the Licensing Law in 1982 mandated that every establishment serving alcohol, nationwide, offer one non-alcoholic beverage priced lower than the cheapest alcoholic drink. The amendment was framed as being 'in the interests of protecting minors'.[245] The removal of alcoholic products from vending machines by the 1984 Youth Protection Act was

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[238] Gunter Croj, 'Drinking-and-driving laws in the Federal Republic of Germany and the Netherlands', ch. 4 in Michael D. Laurence, John R. Snortum, and Franklin E. Zimring, *Social Control of the Drinking Driver* (London: University of Chicago Press, 1988), p. 89.
[239] Hansard, 'Road Traffic (Seat Belts) Bill', Parliamentary debates, 964 (22 March, 1979), cc. 1766-7, 1802-23; 'Amendment of Prescribed Limits',Parliamentary debates, 136 (28 June, 1988),cc. 225,229,240.
[240] Valverde, *Diseases of the Will*, p. 143.
[241] Greenaway, *Drink and British Politics since 1830*, p. 180.
[242] Home Office, *Report of the Departmental Committee on Liquor Licensing in England and Wales*, cmnd 5154 (London: HMSO, 1972).
[243] Hansard, 'The Erroll Report on Licensing Laws',Parliamentary debates, 340(27 March, 1973), c.1000.
[244] Hansard, 'Road Traffic Bill', Parliamentary debates, 197 (12 June, 1956), c. 873.
[245] Deutscher Bundestag, Plenarprotokolle, 9/133 (2 December, 1982), p. 8257.

designed to prevent the apparently common practice of '*Bierholen'* ('the fetching of beer for the father'), to break down the cultural acceptance of alcohol in the family home from a young age.[246] These regulations, though effecting policy convergence with Britain, were framed in terms of the national values of protecting children and the family.

More reflective of convergence in the definitions of health risks, were the moves in West Germany toward whole-population conceptions of risk. Despite comparatively laggard licensing regulations, West Germany arguably led Britain on official adoption of the recommended alcohol unit. The *Bundestag* endorsed the suggestion by the DHS, on 29th April 1980, that the 'normal' daily consumption guidelines of 80 grams (10 units) of alcohol was too high, and should be lowered to 20-25 grams for women and 60 grams for men (about 3 units for women and 7.5 units for men, per day, in the British measurements).[247] Recommended alcohol units were not endorsed by government in Britain until 1984, when a report by the DHSS, *Drinking Sensibly,* and HEC pamphlet, 'That's the Limit', publicised the first set of official weekly alcohol guidelines, describing the 'safe limit' as 18 units for men and 9 units for women, per week, and 'too much' as 56 units for men and 35 for women.[248] The 'sensible limits', beyond which an individual could avoid risking their health, were adjusted to 21 units per week for men and 14 units for women in reports by the Royal Colleges of Physicians, General Practitioners, and Psychiatrists in 1986-7, with 36 units for men and 22 units for women described as 'too much' by the HEC.[249]

Medical responses to the 1987 limits, expressed in a lecture by Robert Evan Kendall of the Royal College of Psychiatrists in that year, reflected the diverse and international character of the alcohol research community. A critique by George Godber, director of the HEC and former Chief Medical Officer to the DHSS, was published in the *British Journal of Addiction* alongside responses by D.J. Pittman, of Washington University St Louis' sociology department; a professor of psychiatry from the University of the West Indies, Trinidad; a number of British medical doctors; and the Addiction Research Foundation of Toronto, Canada.[250] Godber, who had been a key player in the initial RCP report on smoking, espoused the value of this international network, suggesting that much could be learned from greater awareness of

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[246] Deutscher Bundestag, Plenarprotokolle, 10/47, (19 January, 1984), p. 3392.
[247] Deutscher Bundestag, Plenarprotokolle, 8/217, (14 May, 1980), p. 17462
[248] House of Commons Science and Technology Committee, *Alcohol Guidelines, Eleventh Report of Session 2010-12* (London: HMSO, 2012), p. 7.
[249] Ibid.
[250] Various, 'Commentaries on R.E. Kendell's paper Benno Pollak lecture "Drinking Sensibly"', *British Journal of Addiction*, 82: 12 (1987), pp. 1289-1300.

research in Scandinavia, France, the USA, and Canada.[251] In a lecture at Green College, Oxford in 1988 he described the 1974 report by Marc Lalonde, *A New Perspective on the Health of Canadians* – which emphasised individual health education and responsibility for health risk management – as 'one of the most important health publications of this century', and depicted the subsequent publication of *Prevention and Health, Everybody's Business* by the DHSS in Britain and *Disease Prevention, Health Promotion* in the USA, as complementary efforts building upon each other to 'set up targets… with even greater precision'.[252] In West Germany, the Lalonde Report does not appear to have exercised any significant influence over federal government thinking, at least not as expressed in the *Bundestag*, but health education strategies were informed by an awareness of tobacco and alcohol education schemes in Sweden.[253] While the new recommended units enlarged the number of drinkers to which health risks applied in both Britain and West Germany, their introduction does not seem to have prompted any shift in policy strategy within the 1980s. Although presented as new medical advice, the measurements were driven by existing policy knowledge and official concern about broader 'problem' drinking, as well as an existing preference for individual health education as a policy tool. Enlarging the population to which strategies should apply, however, would inform greater convergence on alcohol policy, and new strategies of health information, after 1990.[254]

International research networks also shaped new evidence on the health risks of passive smoking, and that this 'new' risk was accepted so quickly by policy-makers in both Britain and West Germany reflects its adaption to pre-existing ideas about the dangers of second-hand smoke. In 1981, the *British Medical Journal* published new epidemiological research from Japan reporting a higher incidence of lung cancer in the non-smoking wives of heavy smokers.[255] The danger of passive smoking was endorsed by the DHSS following a report of the Independent Scientific Committee on Smoking and Health (ISCSH)[256] in 1988. The West German government, however, had long accepted a probable danger from second-hand smoke. Asked in 1968 about the risk posed to non-smokers by the concentration of nicotine and ash particles in an enclosed space with someone smoking, the Minister for Health responded that

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[251] George Godber, 'The NHS in an international setting', *Health Bulletin*, 40:2 (1982), pp. 67; 75.
[252] Wellcome Library, Sir George Godber papers, GC/201/A/1/37/2, Lecture text, 'The NHS: Origin and Early Development', 18 January 1988.
[253] Deutscher Bundestag, Plenarprotokolle, 8/201 (13 February, 1980), pp. 16116-7.
[254] Thom, *Dealing with Drink*, p. 207.
[255] Berridge, 'Science and Policy', p. 153-4.
[256] An advisory committee established in 1973, initially composed of independent and tobacco industry experts, and charged with 'harm reduction' by government; conducted New Smoking Material research and consumer testing; by the late-1970s, more hostile to industry and no longer comprised industry membership. See: Berridge, *Marketing Health*, pp. 137-47, 210.

while research was not extensive, the government did not deny the potential hazard posed by second-hand smoke, suggesting it could be important to educate smokers that their habit might pose to their peers 'not only a bother, but also a health risk'.[257] The issue of second-hand smoke, and use of the term '*Passivrauchen'* (passive smoking) intensified in the *Bundestag* from the mid-1970s, especially following an assembly of non-smokers' groups in Bad Neuenahr from 15th to 17th November, 1974. A key speaker at the event, Doctor F. Schmidt, had had a persistent correspondence with the Ministry of Finance from January to April that year, about the youth protection implications of the tobacco tax. Initially, the Ministry had issued a disdainful response, but Schmidt's persistence with two further letters brought the inquiry to the attention of the Minister himself, as well as the BMJFG.[258] In Bad Neuenahr, Schmidt called for smoking bans on public transport, and in workplaces, taxis, hopsitals, and schools, to protect non-smokers from the dangers of *Passivrauchen*.[259] The 'Non-Smoker's Congress' was reported across the country, in the *Suddeutsche Zeitung* (München), *Frankfurter Allegemeine*, *General-Anzeiger* (Bonn), *Abendpost* (Frankfurt), *Handelsblatt* (Düsseldorf), and *Stuttgarter Zeitung*.[260] The response to the conference may have contributed to early recognition of the health risks of passive smoking by the federal government.

In March 1976, the government drafted a Non-smokers Protection Program, opening with the clear assertion that, 'Non-smokers are burdened by the habits of smokers. The health of non-smokers can be impaired by the repeated long-term effects of tobacco smoke'.[261] Concerns about smoking in the workplace were delegated to the *Länder*, and bans on smoking in hospitals to the hospital associations, but the central government would oversee health education strategies 'appealing to the self-control of smokers'.[262] It was thought that by asking smokers to consider whether their actions were 'considerate enough to non-smokers', the 'psychological conflict' of smokers who continued to smoking in spite of understanding the personal health risks, could be overcome.[263] In 1977, the BMJFG emphasised in parliament the need to ensure that 'the understanding of the smoker' was that his or her actions 'forced' others to smoke.[264] Over a decade before the passive smoking link was formally endorsed by the British

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[257] Deutscher Bundestag, Plenarprotokolle, 5/190 (10 November, 1968), p. 10271.
[258] Bundesarchiv, Bundesministerium der Finanzen, B 126/82439, correspondence between Prof. Dr. Med. F Schmidt and Herr Dr. Schirmer, 21 January to 24 April 1974.
[259] Bundesarchiv, Bundesministerium der Finanzen, B 126/82439, speech text, 'Der Kampf gegen das Rauchen als vorrangige Aufgabe der vorbeugenden Medizin und des Umweltschutzes', November 1974.
[260] Bundesarchiv, Bundesministerium der Finanzen, B 126/82439, newspaper clippings, November 1974.
[261] Bundesarchiv, Bundesministerium der Finanzen, B 126/82439, 'Entwurf der Nichtraucherschutz-program der Bundesregierung', p. 4.
[262] Ibid, pp. 10, 26-9.
[263] Ibid, pp. 10, 31-2.
[264] Deutscher Bundestag, Plenarprotokolle, 8/40 (9 September, 1977), p. 3124.

government, West German health education was using ideas about passive smoking to shape behaviour. In addition, a new brochure, 'Fifteen Seconds for Thought' was distributed to doctors to encourage smokers to quit, representing a new direction in West Germany toward directly targeting smokers.[265] This strategy had the effect of convergence with Britain, where, as mentioned in chapter one, the distribution of quit information by GPs was expanded in response to new ideas about addiction, to which we will come shortly.

In Britain, the explicit debate about 'passive smoking' was sparked by the 1981 evidence from Japan, but the issue of smoking as a 'nuisance' to non-smokers had been topical in parliament in the 1950s, and the idea of 'involuntary smoking' having an adverse biological impact was already present among policy-makers in the late 1970s.[266] Although the Scottish Health Education Council had used the slogan, 'Smoking gets right up other people's noses!' from the mid-1970s, in 1984 the government described passive smoking as still 'not a proven risk', given the RCP's 'vague' remarks on it in the 1983 report, *Health or Smoking?*.[267] Berridge describes endorsement of the passive smoking evidence by the end of the decade as a 'cultural tipping point', beyond which smokers could no longer be seen as harming only themselves, and smoking as no longer the norm, but an act of social deviance.[268]

The culture around smoking never became so condemnatory in West Germany, despite the early incorporation of the health risk of passive smoking into policy knowledge. A more solidaristic, and legalistic, discourse dominated in West Germany. While expressing an intention to act on non-smoker protection in public buildings, the health ministers of the *Länder* were keen to downplay the non-smoker's rights discourse being promoted by the *Grünen* (Greens)[269], to 'avoid any polarisation' between smokers and non-smokers.[270] Although the EEC had recommended smoking bans on public transport in 1973, the federal government left their negotiation and enforcement to railway industry organisations, resulting in a division of trains into smoking and non-smoking carriages. In 1986, the government argued that the international recommendations – not formal treaties – did not justify federal legislation which might infringe, legally, upon the rights of those who chose to smoke, given that it was already possible for non-

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[265] Bundesarchiv, Bundesministerium der Finanzen, B126/82439, 'Entwurf der Nichtraucherschutz-program der Bundesregierung', p. 32.
[266] Hansard, 'Theatres and Cinemas (Smoking)', Parliamentary debates, 488 *(*4 June, 1951), cc. 763-4; 'Smoking and Health', Parliamentary debates, 903 (16 January, 1976), c. 831.
[267] Hansard, '"Health or Smoking?" Report', Parliamentary debates, 452 (13 June, 1984), cc. 1131-4.
[268] Berridge, *Demons*, p. 185.
[269] Political party founded in 1980 by activists and politicians involved in the transnational environmental and human rights movements.
[270] Deutscher Bundestag, Plenarprotokolle, 11/46 (3 December, 1987), p. 3167.

smokers to protect themselves in non-smoking compartments.[271] International recommendations could not challenge the legal rights enshrined by the *Grundgesetz*.

In Britain, the non-smoker's rights discourse was driven by Action on Smoking and Health (ASH) from the late 1970s, by refining existing moralistic arguments about second-hand smoke with reference to international human rights discourses, legitimated by organisations like the WHO and United Nations.[272] The tobacco industry, rather than smokers themselves, were the villains of these rights-based arguments. The new passive smoking evidence legitimated ideas about non-smokers as victims – but not the victims of smokers, who, based on concurrent developments in psychological science, were becoming recreated as 'addicts'. Chapter one noted that nicotine was first identified as the addictive substance in cigarettes in the RCP's *Smoking and Health Now* (1971). Into the 1980s, the new conception of nicotine as an addictive drug was informed by ideas from health economics about addiction as a 'rational' act, and the quasi-biological approach of psycho-pharmarcology, into which the MRC increasingly directed research resources.[273] Smokers were depicted as dependent, and therefore unfree. Moreover, it was commonly held that all lifelong smokers had picked up the habit as children, and children were still depicted by policy-makers as disproportionately affected by industry marketing; incapable of making an informed, free decision.[274] With the entire population of smokers and non-smokers alike identified as victims of biology, industry, or consequence by the end of the 1980s, the only 'free' choice was the choice *not* to smoke; that is, the 'choice' being vehemently promoted in health education. In the language of Foucaldian neoliberalism; freedom was constituted by un-freedom. The impact of the science of addiction and passive smoking was not only, as described by Berridge, that 'a risk to the general population [was] a much more powerful scientific paradigm for driving policy',[275] but that the choice to smoke entirely lost its legitimacy in Britain, on the authority of scientific and international 'benchmarks'.

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[271] Deutscher Bundestag, Plenarprotokolle, 10/187 (16 January, 1986), pp. 14251-3.
[272] Berridge, *Marketing Health,* pp. 217-21; Nathanson, *Disease Prevention as Social Change*, pp. 11, 141-6.
[273] Berridge, *Marketing Health*, p. 264-5.
[274] Hansard, 'Smoking and Health', Parliamentary debates, 984 (9 May, 1980), cc.785-6; '"Health or Smoking?" Report', Parliamentary debates, 452 (13 June, 1984), cc. 1125, 1156.
[275] Berridge, 'Science and Policy', p. 154.

Benchmarking and international institutions

This section briefly elaborates on the more direct role played by the WHO and EEC in shaping policy responses to the health risks of tobacco and alcohol in this period, with particular reference to taxation; the policy tool which has so often seen West Germany depicted as backward on tobacco regulation.[276] Reference has already been made in chapters one and two to the role of the WHO-endorsed 'disease' model of alcoholism in influencing national policy in Britain and West Germany. This section considers the dynamics of the WHO's influence more directly.

In 1970, the WHO described smoking-related diseases at the 23rd World Health Assembly as 'such important causes of disability and premature death in developed countries that the control of cigarette smoking could do more to improve health and to prolong life in these countries than any other single action in the whole field of preventive medicine'.[277] This quotation, and the organisation's endorsement of tar-content and harm-level testing in the 1975 report of a WHO expert committee, were presented in the House of Commons in January 1976 by two separate speakers, as justification for the de-politicisation of the smoking debate; for its transition 'into the arena of dispassionate, considered assessment by an independent, scientific and medical committee'.[278] The WHO report's recommendation on advertising bans was also noted in January by Health Minister, David Owen.[279] That the same report suggested that, 'universal abstinence from the habit… must be the ultimate aim for all programs', which would have represented a hugely controversial position in British parliament at the time, did not deter members from publicising certain elements of the report with which they agreed.[280] Whether or not the proponents of smoking control shared the WHO's 'ultimate aim', invoking the organisation's recommendations as benchmarks gave legitimacy to policy proposals, especially when 'Britain show[ed] up very badly in the international league'.[281]

The WHO also worked more directly with national governments and organisations throughout the 1970s to promote research into the broader problems of alcohol 'dependency', which would inform discussions at the 1982 World Health Assembly, and help to legitimate its own

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[276] Elliot, 'Smoking for Taxes', p. 1453.
[277] World Health Organisation, *Smoking and its effects on health*, technical report series no. 568 (Geneva: World Health Organisation, 1975), p. 8.
[278] Hansard, 'Smoking and Health', Parliamentary debates, 903 (16 January, 1976), cc. 787-91.
[279] Hansard, 'Tobacco', Written answers, 904 (27 January, 1976), c. 161W.
[280] World Health Organisation, *Smoking and its effects on health*, p. 20.
[281] Hansard, 'Smoking and Health', Parliamentary debates, 984 (9 May 1980), c.781.

recommendations about treatment models.[282] The use of national data in measurements which contributed to new international benchmarks demonstrates that processes of learning were not unilateral; WHO frameworks were not simply imposed. West Germany drew from WHO evidence in 1987, when it declared that, 'the health hazards of passive smoking are scientifically proven'.[283] This external benchmark legitimated a position already negotiated locally, a decade prior. Allen Brandt has depicted the WHO's reluctance to use its formal treaty-making powers up to the 1990s as an aspect of national and international governmental impotence in the face of tobacco industry strength.[284] The absence of compulsion did not, however, prevent national governments from calling upon choice WHO recommendations as benchmarks to justify politically-expedient policies determined in national contexts.

The EEC effected arguably more constraint upon national policy-making than the WHO, and had more of an impact on West German tobacco and alcohol policy than British. Despite the absence of any 'hard' agreements on product labelling, advertising, or public transport smoking bans until 1989, the EEC's 'soft' laws, or recommendations, shaped national policy in line with its 'neo-voluntaristic' mode of governance.[285] The impact of EEC recommendations upon smoking and transport policy in West Germany was described above; tools were shaped by the external benchmark, but negotiated on local terms, within the corporatist *soziale Rechtsstadt* political framework. Both tobacco and alcohol taxation were more significantly constrained by EEC directives, although these were shaped up to 1990 by attempts at common market integration rather than health concerns. The *Bundestag*'s priority with regard to tobacco taxation in the 1950s to 1970s was to retain the advantage of local growers and manufacturers, and to protect these interests first from imported products, and then from integration with foreign markets.[286] The integration of alcohol markets challenged the longstanding government *Branntweinmonopol* (Monopoly on Spirits), which regulated alcohol levels, ingredients, taxation, and marketing of products. In 1979, local distributer *Rewe-Zentral* successfully sued the Federal Ministry of Finance in the European Court of Justice, for the right to sell a French *Crème de Cassis* of only 15% alcohol, rather than the minimum 25% stipulated for fruit liqueurs. Although the ruling forced numerous subsequent exceptions, the CDU government

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[282] Room, 'The World Health Organisation and Alcohol Control', p. 89-90.
[283] Deutscher Bundestag, Plenarprotokolle 11/46, 3 December 1987, pp. 3161-3.
[284] Brandt, *The Cigarette Century*, p. 471.
[285] Gerda Falkner, Oliver Treib, Miriam Hartlapp, and Simone Leiber, *Complying with Europe: EU Harmonisation and Soft Law in the Member States* (Cambridge: Cambridge UP, 2005), pp. 3-4.
[286] Deutscher Bundestag, Plenarprotokolle, 1/66 (2 June, 1950), p. 2417; Plenarprotokolle, 4/13 (31 January, 1962), p. 344; Plenarprotokolle, 4/159 (27 January, 1965), pp. 7829-39; Plenarprotokolle, 7/144 (24 January, 1975), p. 9985.

remained reluctant to relinquish the *Branntweinmonopol* in 1984.[287] Kurzer describes the process of policy convergence through institutional integration as 'emotional'; challenging long-standing national structures and ideas, and delaying the harmonisation of laws.[288] This delay is evident in tobacco and alcohol taxation in Europe, the first attempts at harmonisation commenced in 1962 before being postponed 'indefinitely' in 1986. In in 1989, the content of tobacco warning labels was harmonised throughout the EEC, and a minimum tax of 57% of the sale price enforced, with a non-binding commitment made to move toward a maximum product tar-yield in the early 1990s.[289]

The harmonisation of EEC taxation was complicated by the accession of Britain, along with Ireland, Norway, and Denmark, in 1972.[290] At the time, tobacco taxes in Britain were much the same as in most European nations, with the exception of Norway, Denmark, and Sweden, which had rates far above the rest, but both the Labour and Conservative parties were reluctant to introduce higher tobacco taxation. Labour politicians, including David Owen, opposed higher taxation on the grounds that such a strategy would disproportionately affect the poor, either by increasing the burden of taxation, or by banning cigarette consumption 'by the back door' for a large part of the population.[291] When alcohol taxes were raised in 1974, the changes were depicted by both sides of the house as a revenue-raising strategy.[292] A tension is evident here between the long-standing idea of price-inelastic demand for cigarettes, and emergent discourses about inequalities in health, which would gain pace toward the end of the decade only to be quashed by the incoming Conservative government.[293] The Labour budget of 1974 had also introduced the concept of 'essential' and 'less essential' goods into the structure of the British sales tax, which allowed the government to apply differential taxation to higher-tar tobacco products from 1978 – framed through the discourse of 'harm reduction'.[294] In order to operate tar-related tax rates, derogation was obtained from the EEC to break its 1972 directive on *ad valorem* taxes for cigarettes.[295] In 1976, the CSU opposition in West Germany had proposed the possibility of introducing differential taxation there, to which the government responded that the EEC directive prohibited such a strategy.[296] Britain's circumvention of this

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[287] Deutscher Bundestag, Plenarprotokolle, 10/60 (28 March, 1984), p. 4265.
[288] Kurzer, *Markets and Moral Regulation*, p. 10.
[289] Nick Bosanquet, 'Europe and Tobacco', *British Medical Journal*, 304: 8 (1992), pp. 370-2.
[290] Deutscher Bundestag, Plenarprotokolle, 6/59 (17 June, 1970), pp. 3252-4.
[291] Hansard, 'Smoking and Health', Parliamentary debates, 903 (16 January, 1976), cc. 503-7.
[292] Hansard, 'Budget Resolutions and Economic Situation', Parliamentary debates, 871 (1 April, 1974), cc. 890-1024.
[293] Baggott, *Public Health*, p. 237.
[294] Berridge, *Demons*, 178-9.
[295] Hansard, 'Smoking and Health', Parliamentary debates, 984 (9 May, 1980), c. 776.
[296] Deutscher Bundestag, Plenarprotokolle, 7/236 (9 April, 1976), p. 16560.

rule demonstrates that policies remained nationally-determined, but it also reveals the nation's more distanced relationship with the EEC; West Germany, as one of the original Six, was arguably more compliant.

The Thatcher government in Britain was initially reluctant to continue tax increases, on grounds that the price impact of indirect taxes was undesirable in the context of the election mandate to control inflation and reduce the tax burden.[297] In 1980, tobacco and beer duties were raised only modestly on these grounds. By that time, a number of Labour politicians supported a sharper rise in tobacco and alcohol taxation, and suggested removing tobacco and alcohol from the cost of living index to facilitate action on health grounds.[298] By the end of the decade, former financial secretary Terence Higgins derided the Conservative government's preoccupation with the cost of living index, quipping that tobacco products should instead be calculated in a 'cost of dying index'.[299] By 1989, cigarettes taxation had been increased by nearly 50%, the rate on a twenty-pack approximately 73% of its price, giving Britain one of the highest such taxes in the EEC, with the exception of Denmark.[300] Alcohol taxes, too, had risen, and harmonisation with the impending genesis of the European Union would have led to a 'huge reduction' in the United Kingdom.[301]

The truly remarkable shift, since the mid-1970s, was the new sentiment expressed by British members of parliament, so that, by 1984, 'few… would dispute that price is an important determinant of cigarette consumption'. [302] The significant 10p tax rise of that year was justified on health terms.[303] The Conservative government's rejection of the 1980 Black Report on health inequalities, and Labour party's abandonment of its inequality-based anti-taxation line appear to have partly facilitated the shift, in the context, identified by Berridge, of an overall drop in tobacco consumption, reflecting a change in public opinion, and growing pressure from ASH and the BMA, as well as the Royal Colleges, to act on alcohol and tobacco using taxation.[304] The WHO, from 1980, also favoured taxation for alcohol control.[305] While Britain became an

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[297] National Archives, Cabinet Office, CAB 129/207/5, 'Public Expenditure: Proposals for the years after 1980-81', 7 September 1979.
[298] Hansard, 'Smoking and Health', Parliamentary debates, 984 (9 May, 1980), c. 710.
[299] Hansard, 'Budget Resolutions and Economic Situation', Parliamentary debates, 149 (20 March, 1989), c.781.
[300] Cairney et al, *Global Tobacco Control*, p. 102; Hansard, 'Tobacco (Taxation)', Written answers, 153 (23 May, 1989), c. 441W.
[301] Hansard, 'European Community', Parliamentary debates, 134 (26 May, 1988), c. 568.
[302] Hansard, '"Health or Smoking?" Report', Parliamentary debates 452 (13 June, 1984), c. 1154.
[303] Ibid, c. 1154-5.
[304] Berridge, *Demons*, pp. 178-9.
[305] Thom, *Dealing with Drink*, p. 111.

early-mover on punitive taxation as a public health strategy, this only foreshadowed a move, after 1990, toward taxation as a policy tool in other continental nations, including in Germany – where the concept of price elasticity for *Genussmittel* had been publicly-endorsed since the 1950s.[306] The timing of these moves reflected local political factors, as well as West Germany's closer relationship with the EEC, in the process of European integration.

While the use of international standards and benchmarks in Britain and West Germany reflects the increasing internationalisation of scientific and policy knowledge about the health risks of alcohol and tobacco, contributing to a degree of policy convergence, the policies which were legitimated by international benchmarks were still shaped by distinct national experiences.

[306] Deutscher Bundestag, Plenarprotokolle, 2/178 (7 December, 1956), p. 9894.

Conclusion

This dissertation has compared the discourses around health risks and policy responses related to alcohol and tobacco in Britain and West Germany, as a lens through which to interpret the different national experiences of neoliberalisation in public health, between 1948 and 1990. Informed by the perspective of 'actually existing neoliberalism', the comparative approach has highlighted the national specificities of changing public health responses, as they reflect changing – and enduring – political structures and ideologies identified with reference to the development of different welfare states. Often driven by key areas of contention in the secondary literature on tobacco control, comparisons with alcohol policy have served to enlighten an understanding of policy-makers' conceptions of the health risks of both substances.

The first and third chapters elicited the different networks of science and policy which shaped the use of 'expert' knowledge to inform ideas about health risks throughout the period. These networks revealed both enduring differences between the ideological and structural foundations of the British and West German welfare states, and the impact of structural changes between the eras of welfare state expansion, and convergence, shaped in part by the global proliferation of neoliberal ideas. The central chapter argued that, despite enduring differences in the terms upon which policy responses to the health risks of tobacco and alcohol were defined, a common behavioural turn can be observed. Between the early-1960s and late-1970s the strategies of health education shifted so that governments pursued more persuasive techniques to shape individual consumption behaviour, based on new psychological techniques and justified by a new discursive construction of responsibility. That the free, responsible individual came to be defined in both Britain and West Germany as one who was capable of 'choosing' not to smoke reflects not a subscription to neoliberal ideals, nor a static contradiction between freedom and responsibility, but a dynamic process of policy-making played out in specific national contexts.

The implication of policies being shaped significantly by nationally-specific experiences is not that neoliberalism does not matter; quite the contrary. 'Freedom' of trade and ideas, the 'rationalisation' of public health services, and the 'privatisation' of responsibility for health risk management, all represent neoliberal ways of thinking which have had real effects on conceptions of tobacco and alcohol health risks, and policy responses to them. However, the practice of neoliberal policies does not often reflect their ideal. 'Free' markets and 'free' individuals are socially-constructed and underpinned by the state. Attempts at tax harmonisation required numerous 'soft' and 'hard' regulations, and the 'freedom' to market *Crème de Cassis* in West Germany a lengthy legal proceeding. If the risk of excessive consumption is identified

as addiction, and addiction is considered to circumscribe freedom, then the 'choice' to drink or smoke 'too much' is not necessarily 'free'.

The implication of 'actually existing neoliberalism' is not that neoliberalism does not matter, but quite the contrary; that it is insidious. Neoliberal societies rely on the social construction of free markets and free individuals, but neoliberal policy seeks to conceal this process; presenting them as 'dis-embedded' from society.[307] This dissertation has suggested that this 'dis-embedding' is a *dynamic* process where policy-makers adapt neoliberal ideas to national structural and ideological frameworks. The 'privatisation' of responsibility for health risk management is *ideological* but not *actual*, but the individual is incognizant of this fact. That public health policy does not convey the social construction of both health risks themselves and the notion of 'responsibility' conferred, might – to this author's mind – be the source of disturbing psychic consequences. Ideological privatisation might be seen to play a role in augmenting demand for all different forms of *individual* (rather than social) reproduction; medication, meditation, and subscription to guidelines that, in another world, might have offered a recommended daily intake of tobacco units.

Different national experiences of neoliberalisation are distinct, but actually existing neoliberalism is still appreciable in its effect on social policy, and social life.

[307] Cahill, 'The embedded neoliberal economy', p.119.

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